Company Tracking Number: NWAD1_CHGFORM (R01/12)

TOI: H161 Individual Health - Major Medical Sub-TOI: H161.005A Individual - Preferred Provider

(PPO)

Product Name: Applications

Project Name/Number: Revised Applications/NwAd_1ChgForm R01/12

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield

Product Name: Applications SERFF Tr Num: ARBB-127863893 State: Arkansas

TOI: H16I Individual Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 50409

Closed

Sub-TOI: H16I.005A Individual - Preferred Co Tr Num: NWAD1_CHGFORM State Status: Approved-Closed

Provider (PPO) (R01/12)

Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Christi Kittler, Yvonne Disposition Date: 12/07/2011 McNaughton, Frank Sewall, Rita

Thatcher, Evelyn Laney

Date Submitted: 12/06/2011 Disposition Status: Approved-

Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Revised Applications Status of Filing in Domicile: Pending

Project Number: NwAd_1ChgForm R01/12 Date Approved in Domicile:

Requested Filing Mode: Review & Approval Domicile Status Comments: Arkansas is state

of domicile.

Explanation for Combination/Other: Market Type: Individual

Submission Type: New Submission Individual Market Type: Individual Overall Rate Impact: Filing Status Changed: 12/07/2011

State Status Changed: 12/07/2011

Deemer Date: Created By: Evelyn Laney

Submitted By: Evelyn Laney Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null Filing Description:

Attached please find forms NwAd1 ChgForm, INDPHI, Non-UndChg Form, U-65 APP DR, U-65 APP FB, U-65 APP IA, U-65 List Bill DR, U-65 List Bill FB, U-65 List Bill IA, Non-UndChg Form Insured-BKD, U-65 APP DR ProposedInsured-BKD, and UndChg Form (R01/12) for your review and approval if indicated.

SERFF Tracking Number: ARBB-127863893 State: Arkansas
Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 50409

Company Tracking Number: NWAD1_CHGFORM (R01/12)

TOI: H161 Individual Health - Major Medical Sub-TOI: H161.005A Individual - Preferred Provider

(PPO)

Product Name: Applications

Project Name/Number: Revised Applications/NwAd_1ChgForm R01/12

In these revised forms under "Authorization to Disclose Protected Health Information", we have added pharmacy benefits manager, and the statement "I understand that information re-disclosed may no longer be protected by federal privacy regulations. "We have also added new language to the bank draft form which states "I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds."

I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19. Please feel free to contact me at 378-2165 with any questions you may have.

Company and Contact

Filing Contact Information

Evelyn Laney, Senior Compliance Analyst exlaney@arkbluecross.com
320 West Capitol, Ste 211 501-378-2165 [Phone]
Little Rock, AR 72201 501-378-2975 [FAX]

Filing Company Information

Arkansas Blue Cross and Blue Shield CoCode: 83470 State of Domicile: Arkansas

601 S. Gaines Street Group Code: Company Type:

Little Rock, AR 72201 Group Name: State ID Number: N/A

(501) 378-2967 ext. [Phone] FEIN Number: 71-0226428

Filing Fees

Fee Required? Yes Fee Amount: \$500.00

Retaliatory? No

Fee Explanation: \$50.00 per form

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

Arkansas Blue Cross and Blue Shield \$500.00 12/06/2011 54301205

Company Tracking Number: NWAD1_CHGFORM (R01/12)

TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider

(PPO)

Product Name: Applications

Project Name/Number: Revised Applications/NwAd_1ChgForm R01/12

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	12/07/2011	12/07/2011

Company Tracking Number: NWAD1_CHGFORM (R01/12)

TOI: H161 Individual Health - Major Medical Sub-TOI: H161.005A Individual - Preferred Provider

(PPO)

Product Name: Applications

Project Name/Number: Revised Applications/NwAd_1ChgForm R01/12

Disposition

Disposition Date: 12/07/2011

Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Company Tracking Number: NWAD1_CHGFORM (R01/12)

TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider

(PPO)

Product Name: Applications

Project Name/Number: Revised Applications/NwAd_1ChgForm R01/12

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

SERFF Tracking Number: ARBB-127863893 State: Arkansas
Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 50409

Company Tracking Number: NWAD1_CHGFORM (R01/12)

TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider

(PPO)

Product Name: Applications

Project Name/Number: Revised Applications/NwAd_1ChgForm R01/12

Form Schedule

Lead Form Number: NwAd1_ChgForm (R01/12)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 12/07/2011	gForm	n Application/Application Enrollment Form	Revised	Replaced Form #: NwAd1_ChgForm (R01/12) Previous Filing #: NwAd1_ChgForm (R11/11)		NwAd1_ChgF orm (R01- 12).pdf
Approved- Closed 12/07/2011	R01/12	Application/Application Enrollment Form	Revised	Replaced Form #: INDPHI R01/12 Previous Filing #: INDPHI 5/03		INDPHI R01- 12.pdf
Approved- Closed 12/07/2011	UndChg	Application/Application Enrollment Form	Revised	Replaced Form #: Non-UndChg Form (R01/12) Previous Filing #: Non-UndChg Form (R10/11)		Non-UndChg Form (R01- 12).pdf
Approved- Closed 12/07/2011	U-65 APP DR (R01/12)	Application/Application Enrollment Form	Revised	Replaced Form #: U-65 APP DR (R01/12) Previous Filing #: U-65 APP DR (R11/10))	U-65 APP DR (R01-12).pdf
Approved- Closed 12/07/2011	FB	Application/Application Enrollment Form	Revised	Replaced Form #: U-65 APP FB (R01/12) Previous Filing #: U-65 APP FB (R10/11)		U-65 APP DR (R01-12).pdf
Approved- Closed 12/07/2011	IA (R01/12)	Application/Application Enrollment Form	Revised	Replaced Form #: U-65 APP IA (R01/12) Previous Filing #: U-65 APP IA (R10/11)		U-65 APP IA (R01-12).pdf

SERFF Tracking Number: ARBB-127863893 State: Arkansas Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 50409 Company Tracking Number: NWAD1_CHGFORM (R01/12) TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO) Product Name: Applications Project Name/Number: Revised Applications/NwAd_1ChgForm R01/12 Approved- U-65 APP Application/Application Revised Replaced Form #: U-U-65 List Bill List Bill DR Enrollment DR (R01-Closed 65 APP List Bill DR 12/07/2011 (R01/12) Form 12).pdf (R01/12)Previous Filing #: U-65 APP List Bill DR (R11/10) Application/Application Revised U-65 List Bill Approved- U-65 List Replaced Form #: U-Closed **Enrollment** FB (R01-Bill FB 65 List Bill FB 12/07/2011 (R01/12) Form 12).pdf (R01/12)Previous Filing #: U-65 List Bill FB (R10/10)Approved- U-65 List Application/Application Revised Replaced Form #: U-U-65 List Bill **Enrollment** IA (R01-Closed Bill IA 65 List Bill IA 12/07/2011 (R01/12) Form 12).pdf (R01/12)Previous Filing #: U-65 List Bill IA (R11/10) UndChgFm_ Approved- UndChg Application/Application Revised Replaced Form #: Closed R01-12.pdf Form **Enrollment** UndChg Form 12/07/2011 (R01/12) Form (R01/12)Previous Filing #:

UndChg Form

(R10/11



Newborn/Adopted Child Change Form

This form should be completed if you are requesting to add to your policy a newborn within 90 days of birth or adopted child within 60 days of filing the adoption petition. Documentation is required to add an adoptive child(ren) and the appropriate documentation such as a copy of adoption papers or other court papers must accompany this form, in order to support this change. If you are requesting one of these additions outside these time limits, you will need to complete an **Underwriting Change Form**. To request an **Underwriting Change Form**, call 1-800-238-8379.

Medical underwriting may apply to the addition of a newborn/adopted child. Please refer to your policy for more information.

Please Note: Do not submit this change form prior to a newborn's date of birth or prior to the filing of the adoption petition.

BEFORE COMPLETING THIS CHANGE FORM, PLEASE READ THE FOLLOWING INSTRUCTIONS:

- This form is a legal document. It is very important that you provide **all** requested information and that it is accurate and legible.
- Please ensure that all required parties sign and date the form.
- This form must be completed in dark blue or black ink.
- If you make a mistake, please mark through the incorrect information, initial it and then provide the correct information.
- Do not use liquid paper, correction tape or "white out" to correct any mistakes you
 make on this application.
- Any attached sheets must be signed and dated.
- We strongly encourage you to make a photocopy of this completed form for your records.

IMPORTANT INFORMATION REGARDING GRANDFATHERED PLANS

Your Arkansas Blue Cross and Blue Shield coverage **may** be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Arkansas Blue Cross and Blue Shield Customer Service at 1-800-238-8379. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov



IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

Name of Newborn/Adopted Child(ren) (Please	Print)	
	Parent/Legal Guardian's Signature	// Date



Newborn/Adopted Child Change Form

Return To: Arkansas Blue Cross and Blue Shield, Attn: Individual Underwriting, P.O. Box 2181, Little Rock, AR 72203-2181

1 POLICYHOLDER	INF	ORMATION									
Member ID:			Group N	umber	:			Date of	f Birth: _	/	
First Name:		M.I.:	Last	Name):			Social	Security	No.:	
Residential Address:					_ City	y:		State: _		Zip:	
2 CONTACT INFO	RMA	ΓΙΟΝ									
Primary Phone Number	r	Alternate Pl	none Nui	mber	Bes	t Time to Ca	all	E-Mail Ad	dress		
()		()			A	M PM	l				
3 NEWBORN OR A	DOF	TED CHILE	(REN)	INFO	DRM	ATION					
Indicate below the nar	ne of t	he dependen	t(s) you	want	adde		olicy	/.			
First Name	M.I.	Last Na	me	Suffix	Sex	Date of Birth		Adoption tition Date		Security lo.	Newborn or Adopted
							╄				
							╄				
Does the proposed child	. ,		policyh	older?		_Yes	_No)			
If "no," please provide the		ŭ						_			
Name of Parent/Gu											
Address:											
Primary Phone Nur	nber: ())			^	Alternate Pho	one	Number: ()		
Best Time to Call:	AM	PM									
PLEASE READ BE	FOR	E SIGNING									
I UNDERSTAND: (1) The insurance applied for shall not become effective until the date shown on my schedule of benefits and the adjusted premium, if applicable, is paid in full. (2) If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on intentional misrepresentations of material fact or fraud. (3) My signature authorizes Arkansas Blue Cross and Blue Shield to coordinate benefits under this policy with other insurance I have which is subject to coordination. (4) Arkansas Blue Cross and Blue Shield may phone me for additional information that may help with the timely processing of my application. In signing below, I: represent that the statements and answers given in this application and any signed and dated addendum to this application are true, complete and correctly recorded.											
I certify that I signed this change form in the state of Arkansas.											
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.											
Signature of Policyholder X									Date Sign	ed	
FOR HOME OFFIC	F FN	DORSEME	NTS								
. Sit Home of Ho	_ E14		110								

Important Note: If the addition of your newborn or adopted child requires medical underwriting, you will receive a telephone call from our Underwriting Division. In such instances, your newborn or adopted child will be added to your policy only upon

approval by our Underwriting Division; and the effective date of coverage will be subsequent to the approval date.



An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 2181, Little Rock, AR 72203-2181



IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

	This authorization must be signed by each ap	plicant age 18 or older.	
~	Print Name(s)	Signature	Date
18			
s ag Ider			
licants ag and older			
Applicants age and older			
⋖			
	List applicants under age 40 (Drint Name)		
	List applicants under age 18 (Print Name).		
der	 -		
Applicants under age 18			
icants u age 18			
plic			
Ар			
		Parent/Legal Guardian's Signature (if policy for a minor)	Date
		orginature (ii policy for a million)	



Individual/Family Health Insurance Non-Underwriting Change Form

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS CHANGE FORM. CHANGE FORM MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This form is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This change form must be completed in dark blue or black ink. Forms completed in pencil will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this form.
- Any attachments submitted with the change form must be signed and dated.
- · Do not send any money with this change form.
- Please ensure all required parties have signed and dated the change form prior to submission.
- We strongly recommend you make a copy of this completed change form for your records.

IMPORTANT INFORMATION REGARDING GRANDFATHERED PLANS

Your Arkansas Blue Cross and Blue Shield coverage **may** be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Arkansas Blue Cross and Blue Shield Customer Service at 1-800-238-8379. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

INSTRUCTION SHEET

Changes to your policy can only be made during the annual open enrollment period, unless the change is a result of a qualifying life event, such as birth of a child, adoption, loss of other coverage, marriage, etc.

When you are completing this form, please refer to your Arkansas Blue Cross and Blue Shield identification card for your Member ID and Group #. This information must be entered correctly under Section 1 in order to process your request.

Effective Date: The effective date for any changes requested from a "qualifying life event" will be the next available effective date following approval. Changes requested during the annual open enrollment period will become effective the following January (the 1st or 15th of the month, depending on your billing date).

Billing Change: Any request made to change your billing will be based on the current billing date of your policy.

Section 3 - Address Changes

Any change to your current address information can be completed in **Section 3 – Address Changes**. We have provided three separate listings for this information. Only complete for addresses that are changing.

Residential – This address will be noted as your physical place of residence.

Mailing – Correspondence such as letters and Explanations of Benefits (EOBs) will be mailed to this address.

Billing – All billing invoices will be mailed to this address.

Section 5 – Name Change

Documentation is required for any name change request. Please complete **Section 5 – Name Change** and attach appropriate documentation such as, a copy of your Marriage License, Divorce Decree, Adoption papers or other court papers to support the change.

Section 7 - Delete Person(s) From The Policy

Qualifying life event changes allow you to make changes to your policy outside of the annual open enrollment period. Such events include, but are not limited to (please ensure all documentation is included):

- Divorce/Legal Separation (requires a copy of divorce decree/legal separation)
- No longer an Arkansas resident (requires a date of move or date of notification)
- Marriage (requires a copy of the marriage certificate)
- Becoming eligible for other coverage (requires proof of eligibility of other coverage)
- Death (requires a copy of death certificate)

In the event you would like to **terminate coverage** for a covered person, including the policyholder, you can do so by completing **Section 7 – Delete Person(s) From The Policy**.

OR

You have the option to **maintain the person's coverage** by splitting him/her off onto a new individual policy with identical coverage. This will completely remove him/her from your coverage and create a new policy for the covered person. You can make this change by completing **Section 9 – Split Policy**. A signature is **required** by **both** the current policyholder and new policyholder. **Important Note:** Complete one change form for each new policy you are requesting.

Section 8 - Ownership Changes

If both the policyholder and spouse are retaining coverage, but you would like to change the ownership of the policy from the current policyholder to the spouse, complete **Section 8 – Ownership Change**. Both the current policyholder and new policyholder must sign the change form.

Section 11 - Benefit Changes

- This section reflects all benefit options available for your policy.
- Please complete only the section for your specific policy.
- If you are unsure of your product name, use the product group numbers listed as a reference. Your product group number can be found on your identification card under **Group #**. It will be the first six numbers before the dash.
- If you still have questions, call customer service at 1-800-238-8379.



Non-Underwriting Change Form For Current Policy

Return To: Arkansas Blue Cross and Blue Shield, Attn: Change Request, P.O. Box 2181, Little Rock, AR 72203-2181 or Fax to: 501-378-3248

1 CURRENT POLICE	CYHOLDER IN	NFORM/	NOITA						
Member ID:		Gro	oup Num	ber:			Date o	of Birth:	<u>//</u>
First Name:			M.I.:_	La	st Name:				
2 CONTACT INFOR	OMATION .								
		Nimalana	Deat Time	- 4- O-III	Г	: I A alalma a a	_	I How do you	u prefer we
Primary Phone Number ()	()	I		e to Call PM	E-M	nail Address	5		ate with you?
			IANGES					-!	
	Please skip sec	tions that	t do not a	ipply to t	he change	e(s) you are	e makii	ng.	
3 ADDRESS CHAN									
Residential Address:	Street								
	City					S	State	Zip	
Mailing Address:	Street								
	City					s	state	Zip	
Billing Address:	Street								
•	City							Zip	
4 POLICY CHANGE	FI IGIBII ITY	7							
			change re	aqueet					
☐ 1-Annual Open Enrollm☐ 2-Birth☐ 3-Adoption☐ 4-Death☐ 5-Marriage	□ 3-Adoption custody/court order to add child □ 11-Military Reinstatement □ 4-Death □ 8-Loss of employer-sponsored □ 12-Other (Give specific details)								
NOTE: If Change Form is n confirm qualifying life event insurance company, guardia	(i.e. copy of birth o	r death cer	tificate, cop						
5 NAME CHANGE									
Additional documentat	tion required. R	ead instru	uctions fo	or Sectio	n 5 before	completin	ng.		
From: First Name				_ M.I	Las	st Name			
To: First Name									
6 BILLING CHANG	E								
☐ Monthly Bank Draft ☐ Quarterly Invoice ☐ Semi-Annual Invoice ☐ Annual Invoice (Must complete attached bank draft form)									
7 DELETE PERSON(S) FROM THE POLICY									
First Name	M.I.			Last Nar	ne		Suffix	Date of Birt	h

8 OWNERSHIP CHA	NGE				
From: First Name			M.I La	ast Name	
9 SPLIT POLICY					
Indicate the name of the	covered	l person(s) you want co	vered on a separ	rate policy wi	th identical coverage.
First Name	M.I.	Last I	Name	Suffix	Date of Birth
Primary Phone Number	Altern	ate Phone Number	Best Time to Call	E-Mail Add	dress
()	()	AM PM		
Please provide Address	Informat	ion for new Policyholde	er ONLY:		
Residential Address:	Street				
					tateZip
Mailing Address:	Street				
					tateZip
Billing Address:	Street				
					tateZip
Please set up the billing Monthly Bank Draft (Must complete attached b	ank draft fo	☐ Quarterly Invoic orm)			☐ Annual Invoice
☐ Term Life Insurance	□ Materr	•	•		
11 DENEELT CHANGE	EC	(Only a	pplicable for Comprehe	ensive Blue PPO a	and Comprehensive Blue PPO II)
11 BENEFIT CHANGES IMPORTANT NOTE: Increasing the calendar-year deductible means that any claims processed by Arkansas Blue Cross after the effective date of change, regardless of the date of the service(s), will be applied to the new higher deductible. AccessBlue PPO Group # 700101-700104 or 700201-700204 - Grandfathered					
Increase my calendar-y			□ \$1,000	□ \$2,500	
1			. ,		
AccessBlue PPO Group # 300101-300104 or 300201-300204 - Non-Grandfathered Increase my calendar-year deductible to: □ \$1,000 □ \$2,500					
A Basic Blue PPO Group # 710000 or 720000 - Grandfathered					
Delete the following benefit: □ Physician Office Visits Rider □ Prescription Drugs Rider					
BlueCare PPO Group # 600010-600016 or 600020-600026 - Grandfathered BlueCare PPO Plus Group # 600030-600036 or 600040-600046 - Grandfathered					
Increase my calendar-y Increase my calendar-y *\$2,500 has no coinsurar	ear coins	surance maximum to:	□ \$1,000	□ \$1,500 □ \$2,000	·

11 BENEFIT CHANGES (continued) IMPORTANT NOTE: Increasing the calendar-year deductible means that any claims processed by Arkansas Blue Cross after the effective date of change, regardless of the date of the service(s), will be applied to the new higher deductible. Blue Choice Group # 771000-771023 or 781000-781020 - Grandfathered

Increase my calendar-year deductible and benefit to: \$500 Deductible Options ☐ \$1,000 OOP* coinsurance maximum and EC Rx plan ☐ \$2,000 OOP* coinsurance maximum and CC Rx plan ☐ \$2,000 OOP* coinsurance maximum and EC Rx plan	☐ \$30/\$50 cc ☐ \$30/\$50 cc ☐ No physicia	ctible Options ppay and CC Rx pl ppay and EC Rx pl an copays** and C an copays** and E	an CC Rx plan		
\$1,000 Deductible Options ☐ \$1,000 OOP* coinsurance maximum and CC Rx plan ☐ \$1,000 OOP* coinsurance maximum and EC Rx plan ☐ \$2,000 OOP* coinsurance maximum and CC Rx plan ☐ \$2,000 OOP* coinsurance maximum and EC Rx plan	☐ \$30/\$50 cc ☐ \$30/\$50 cc ☐ No physicia	uctible Options opay and CC Rx pl opay and EC Rx pl an copays** and C an copays** and E	an CC Rx plan		
\$2,500 Deductible Options ☐ No OOP* coinsurance and CC Rx plan ☐ No OOP* coinsurance and EC Rx plan ☐ \$2,000 OOP* coinsurance maximum and CC Rx plan ☐ \$2,000 OOP* coinsurance maximum and EC Rx plan *Out-of-Pocket	☐ \$30/\$50 cc ☐ \$30/\$50 cc ☐ No physici: ☐ No physici:	processes of the control of the cont	an C Rx plan C Rx plan		
Blue Select Group # 601000-601007 or 602000-602007	- Grandfathered	I			
Increase my calendar-year deductible to: Increase my calendar-year coinsurance maximum to: Delete the following benefit:	□ \$1,000	□ \$1,500 □ \$2,000	□ \$2,500		
▲ Blue Solution Group # 770000-770003 or 780000-78	NNN3 - Grandfath	nered			
Increase my calendar-year deductible to:	□ \$1,500	□ \$3,000	□ \$5,000		
Comprehensive Blue PPO Group # 790000-79000 Comprehensive Blue PPO II Group # 791000-798					
Increase my calendar-year deductible to: ☐ \$1,000	□ \$2,500	□ \$5,000	□ \$10,000		
Comprehensive Blue PPO Group # 300000-300007	or 390000-39000	7 - Non-Grandfat	hered		
Comprehensive Blue PPO II Group # 391000-398	000 or 301000-3	08000 - Non-Grar	ndfathered		
Increase my calendar-year deductible to: $\ \square$ \$1,000	□ \$2,500	□ \$5,000	□ \$10,000		
Comprehensive Blue PPO III Group # 700008-70 Increase my calendar-year deductible to: ☐ \$1,500 ☐ \$10,000	□ \$2,500 E	790016 □ \$5,000 □ \$7. □ \$20,000 □ \$2	,		
Conversion Group # 902100-902140 - Grandfathered Conversion Group # 302100-302140 - Non- Grandfathered Increase my calendar-year deductible and benefit to: \$\text{500 Deductible, 80/20\% Coinsurance, \$5,000 Calendar-Year Coinsurance Maximum}\$ \$\text{1,000 Deductible, 80/20\% Coinsurance, \$5,000 Calendar-Year Coinsurance Maximum}\$					

□ \$1,000 Deductible, 80/20% Coinsurance, No Calendar-Year Coinsurance Maximum

HSA Blue PPO Group # 730000-730021 or 740000-740021 - Grandfathered HSA Blue PPO Plus Group # 750000-750021 or 760000-760021 - Grandfathered

Increase my calendar-year deductible to:

□ \$3,100 Individual/\$6,250 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum

□ \$3,100 Individual/\$6,250 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Calendar-Year Coinsurance Maximum

□ \$6,050 Individual/\$12,100 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum

		deductible means that any claims pross of the date of the service(s), will be		
HSA Blue PPO II Gr	oup # 711000-711005 o	r 722000-722005 - Grandfathered		
Increase my calendar-yea	r deductible to:	□ \$2,500 Individual/\$5,000 Family Dec		
LICA DI LA DDO II A	# 244000 04400	□ \$5,000 Individual/\$10,000 Family De	ductible	
Increase my calendar-yea		r 322000-322005 - Non-Grandfathered ☐ \$2,500 Individual/\$5,000 Family Dec	luctible	
-		□ \$5,000 Individual/\$10,000 Family De	eductible	
Increase my calendar-yea	r deductible and bene	fit to:		
Deductible: *Not available with Plan A (☐ \$1,000 100% Coinsurance)	* 🗆 \$2,500 🗆 \$5,000 🗆 \$10,0	00 🗆 \$25,000	
Choice of Plan: ☐ Plar **Coinsurance Maximum ar	n A: 100%** Coinsurance mount not applicable	e 🗆 Plan B: 80/20% Coinsurance 🛭	Plan C: 50% Coinsurance	
Calendar-Year Coinsurance NOTE: Your coinsurance m			1 \$50,000	
Delete the following Bene	fit: SAE – Suppleme	ntal Accident Endorsement		
PLEASE READ BEFO	RE SIGNING			
I understand: (1) This application may be rejected if the applicant is age 19 or older. (2) If accepted, the insurance applied for shall not become effective until the date shown on my schedule of benefits and the adjusted premium, if applicable, is paid in full. (3) If my application is accepted relying on my representations in this document, any coverage which may be issued to me shall be invalid if based on intentional misrepresentations of material fact or fraud. (4) My signature authorizes Arkansas Blue Cross and Blue Shield to coordinate benefits under this policy with other insurance I have which is subject to coordination. (5) Arkansas Blue Cross and Blue Shield may phone me for additional information that may help with the timely processing of my application. In signing below, I: represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded.				
I certify that I signed this change form in the state of Arkansas.				
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.				
SIGNATURE SECTION	• • • •	riate line only)		
Current Policyholder OR	(Please Print)		Date Signed	
Parent Legal/Guardian's (if policy for a minor)	(Please Sign)			
New Policyholder	X		Date Signed	
COMMENTS				

11 BENEFIT CHANGES (continued)

Pre-Authorized Bank Draft

Monthly Program Sign-up Form

Our monthly bank draft service makes premium payments easy and convenient for you. Just a few steps now help assure your payments are made accurately and timely.

- 1. Complete the information below.

Arkansas Blue Cross and Blue Shield Attn: Cashiers (Drafts)

P.O. Box 3590 Little Rock, AR 72203

Important: Please Read Before Signing

2. Mail this completed authorization form to: I authorize Arkansas Blue Cross and Blue Shield, USAble Life, and the BANK indicated below, to debit my Arkansas Blue Cross and/or USAble Life premium from my checking or savings account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

> I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross and/or USAble Life coverage, UNLESS Arkansas Blue Cross and/or USAble Life has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds

USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue

Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life and critical illness policies referenced in your policy.

Insured's Information	
First Name	Last Name
Address Street City	Apt. No State Zip
Arkansas Blue Cross and Blue Shield Member ID	_,
Please check one of the following: Currently, the insured's premium is not dra	
Bank Account Information	
Bank NameRouting Number	(If different than the insured)
Bank Routing Number	\$ DOLLARS Bank Account Number Check Number
Signature	
Signature Signature of Bank Account After Arkansas Blue Cross receives and processe the effective date of your first scheduled draft. We you. Thank you for your business!	Holder es this completed authorization form, you will receive a letter providing e hope you find this bank draft service of value. It is our privilege to serve
	For Office Use Only (please do not write in this space)
Arkansas	ID NO. EFFECTIVE DATE

BlueCross BlueShield





Individual/Family Health Insurance Application

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This application is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This application must be completed in dark blue or black ink. Applications completed in pencil will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this application.
- Any **attachments** submitted with the application must be signed and dated.
- Do not send any money with this application.
- Please ensure all required parties have signed and dated the application prior to submission.
- · We strongly recommend you make a copy of this completed application for your records.

SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older.
- In "Relationship" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 8).
- If any dependents are under age 19 and do NOT reside with the proposed insured, the custodial parent must also sign the application (see *Signature Section* on Page 8).

SECTION 2 – PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

SECTION 4 – U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or green card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- · Applicants must reside in the U.S. at least one year prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

SECTION 12 – REQUESTED EFFECTIVE DATE

• The applicant should check preference for 1st or 15th of the month effective date. This is the applicant's opportunity to request the effective date coordinates with the termination of current health insurance coverage. While we cannot guarantee a specific requested effective date, we will make every effort to accommodate the request. If the application is approved, the effective date will be assigned based on the date of approval. This means retroactive effective dates will not be assigned.

SECTION 16 – TYPE OF COVERAGE

• If applicant is applying for coverage other than "Individual," please indicate if still interested in coverage if one or more applicants is declined or ineligible. If "Yes" is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If "No" is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.



IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seg., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seg. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

	This authorization must be signed by each app	licant age 18 or older.	
8	Print Name(s)	Signature	Date
Applicants age and older			
ican and (
ldd\			
4			
	List applicants under age 18 (Print Name).		
_			
Applicants under age 18			
cants u age 18			
can age			
ppli			
₹			/
		Parent/Legal Guardian's Signature (if policy for a minor)	Date
		orginature (ii policy for a millor)	



Application for Health Insurance

1 WHO IS APP	LYIN	IG								
Read all instructions	for S	Section 1 before co	mpleting	g.						
First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Se	curity No.	Height	Weight
				Self					ftin.	lbs.
									ftin.	lbs.
									ftin.	lbs
									ftin.	lbs
									ftin.	lbs
									ftin.	lbs
									ftin.	lbs
2 PARENT/GU	ARD	IAN (If policy i	s only	for a child	unde	er age 19)				
Additional information	on ma	ay be required. Rea	ad instru	ctions for Sect	ion 2 b	efore comple	ting.			
First	Name	,	M.I.	Las	t Name		Re	lationship (C	heck One)	
							☐ Mother	☐ Stepme		Guardian
2 MADITAL OT	A == 1 1/						☐ Father	☐ Stepfar	ther	
3 MARITAL STA					<i>(</i> '	. , ,				
☐ Single (including	wido	wed or divorced)		☐ Married	(includ	ing separated)			
4 U.S. CITIZEN	SHII	P STATUS								
Additional information										
☐ Yes ☐ No Are	all ap	pplicants U.S. citizer	s? If "no	," please provid	le the r	name(s) of the	applicant(s) w	ho are not l	J.S. citizens	S.
Nar	ne:					Name:				
5 RESIDENTIA	LAD	DDRESS (Must	be pe	rmanent ac	ldres	s - No P.O.	box, pleas	se)		
Street						City		State	Zip	
								AR		
6 MAILING AD	DRE	SS (Complete	only if	f different f	rom r		address)			
Street or P.O. Box						City		State	Zip	
7 BILLING ADI	DRE	SS (Complete	only if	different fr	om r	esidential a	address)			
Street or P.O. Box						City	-	State	Zip	
8 CONTACT IN	FOF	RMATION								
Primary Phone Nun	nber	Alternate Phone I	Number	Best Time to	- 1	E-mail /	Address	I	do you pre	
()		()		AM PM					nunicate wi E-mail E	In you? I Phone
9 HOUSEHOLE	INF	ORMATION								1110110
☐ Yes ☐ No a. □			n the sa	me household	l? If "n	o " provide rea	ason and his/	her name a	and addres	ss.
		:								
		on:				-				
		applicants reside i	n Arkan	sas? If "no." p	rovide	reason and h	nis/her name	and addres	 SS:	
		:		•						
	Reasc									
OFFICE USE O			In This	s Space)						
I.D. No.			Group I				Effective Da	ate		

10 AP	PLICA	N.	T(S) EMPLOYMENT INFORMATION [ap	plicant(s) age 18 and older]					
Name: _			Employer	:					
Job Dut	ies:								
Name: _			Employer	:					
Job Dut	ies:								
11 CL	JRREN	T/	PREVIOUS INSURANCE INFORMATIO	N					
			Will the coverage applied for replace or change coverage is approved by Arkansas Blue Cross a i. If "yes," please provide name of carrier:	current hospital, medical or major medical insurance if this nd Blue Shield and accepted by the applicant?					
☐ Yes	□ No		iii. If "yes," and the coverage does not have a approved by Arkansas Blue Cross and acce	specified termination date, will the coverage terminate if specified by the applicant?					
□ Yes	□ No	b.	Have you recently lost employer-sponsored hea						
□ Yes	□ No	C.	Have you recently "involuntarily" lost other healt	n coverage? If "yes," please provide:					
□ Yes	□ No	Name:Carrier Name: Termination Date:// No d. Will any applicants be continuing any other health insurance? If yes, please provide: Name: Carrier Name: ID# Name: Carrier Name: ID#							
□ Yes	□No	e.	Are any applicants covered by Medicaid (other t please provide name(s) below: Name: Name:	nan Women's Health/Family Planning coverage)? If "yes,"					
□ Yes	□ No	f.	Are any applicants covered by Medicare? If "ye Name: Name:						
12 RE	EQUES	T	ED EFFECTIVE DATE						
Arkansa an effect request will be a	as Blue C tive date ed effect assigned	crosth tive	ss and Blue Shield gives 1 st of the month and 15 th o at coordinates with the termination of current healt date, we will make every effort to accommodate	f the month effective dates. This is your opportunity to request h insurance coverage.* While we cannot guarantee a specific the request. If your application is approved, the effective date effective date guidelines). This means retroactive effective rour coverage to become effective:					
	1st of the	m	onth	ce					
13 DF	RIVER'	S	LICENSE INFORMATION (applicant(s)	age 14 and older]					
			License No. :						
				State:					
				State:					
☐ Yes ☐ Yes	□ No	a. b. c.	has any applicant: Had his or her driver's license suspended or revolute two or more moving traffic violations? Been convicted or charged with driving under the lf you answered "yes," to any of the above questi						
Name: _			Date:	_//Violation(s):					
Name: _			Date:	//Violation(s):					
			OR HOBBY INFORMATION						
☐ Yes		ра	es any applicant intend to pilot a private aircraft; rticipate in sky or scuba diving, ballooning, mount zardous sport, hobby or activity?	race a motor vehicle, boat or snowmobile; or ain climbing, hang gliding or any other					
Name: _				explain:					
Name:			Please	explain:					

15 TRAVEL OUTSIDE THE USA	
☐ Yes ☐ No Is any applicant planning to travel or work outsing ff "yes," please provide the following:	de the USA within the next two years?
Name (list all that apply):	
Country: Expected Length of Stay:	
Reason for Travel:	
16 TYPE OF COVERAGE Pead instructions for Section 16 before completing	
Read instructions for Section 16 before completing.	
☐ Individual ☐ Individual and Spouse ☐ Individual	and Child(ren) Individual, Spouse and Child(ren)
Yes No If you are applying for coverage other than one or more applicants is declined or ineligi	"Individual," do you want to continue the application process if ible?
17 BILLING MODE	
Monthly Bank Draft (Must complete attached bank draft form)	erly Semi-Annual Invoice Annual Invoice
(Mast somplete attached bank didit isim)	
18 BENEFITS SELECTION	
MUSI CHOOSE	ONE BOX ONLY
Comprehensive Blue PPO III	HSA Blue PPO II
☐ \$ 1,000 deductible	
	☐ \$ 1,500 individual/ \$ 3,000 family deductible
☐ \$ 1,500 deductible	5 3,000 family deductible
☐ \$ 2,500 deductible	
☐ \$ 5,000 deductible	¢ 2 500 is divided!/
	☐ \$ 2,500 individual/ \$ 5,000 family deductible
□ \$ 7,500 deductible	Ψ 0,000 failing deddelible
☐ \$10,000 deductible	
□ \$15,000 deductible	¢ 5 000 in divide al/
☐ \$20,000 deductible	☐ \$ 5,000 individual/ \$10,000 family deductible
	410,000 family doddonois
☐ \$25,000 deductible	
19 OPTIONAL BENEFITS SELECTION	
OPTIONAL MATERNITY BENEFITS	
Yes, I want to apply for the maternity benefits.	
	overage has been in effect for 12 months. This benefit
	ents other than a covered spouse cannot purchase the

19 OPTIONAL BENEFITS SELECTION (continued)

OPTIONAL CRITICAL ILLNESS COVERAGE

IMPORTANT NOTE: To be eligible for a Health Savings Account (HSA), you cannot be covered by insurance other than an HSA-compatible plan. Our critical illness policy should be considered "other insurance."

Underwritten and billed separately by USAble Life. USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the critical illness coverage policy referenced here.

Critical Illness Coverage is available only on the proposed insured and spouse. (Proposed insured must be 19-64 years of age.) This coverage pays a lump sum cash benefit upon the first positive diagnosis of a covered critical illness.

Choose only one of the following:								
□ Proposed Insured								
☐ Proposed Insured and Spouse (Spouse must also be applying for health insurance coverage on this application.)								
Choose one of the following coverage amounts: ☐ \$10,000 ☐ \$20,000 ☐ \$30,000								
If both the proposed insured and spouse choose Critical Illness Coverage, the coverage amounts will be the same.								
Replacement: Is this insurance to replace or change other insurance? ☐ Yes ☐ No								
If "yes," give details including name of company								
I understand no person to be insured is also covered by any Title XIX program — Medicaid or any similar name.								

OPTIONAL TERM LIFE

Underwritten by USAble Life and billed with your health insurance. USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life policy referenced here.

Term Life is available only on the proposed insured and spouse. (Proposed insured must be 19 - 64 years of age.)

Choose only one of the following:

- ☐ Proposed Insured
- ☐ Proposed Insured and Spouse (Spouse must also be applying for health insurance coverage on this application.)

Choose one of the following coverage amounts: \Box \$10,000 \Box \$30,000 \Box \$50,000

If both the proposed insured and spouse choose Term Life, the coverage amounts will be the same.

- Benefits will be paid to the designated beneficiary(ies) in one lump sum.
- Premiums are based on the age of the oldest person applying for coverage and increase when that person's age moves to
 the next age bracket. Your monthly premiums will be billed with your Arkansas Blue Cross and Blue Shield health insurance
 coverage.
- Your Term Life coverage will become effective at the same time as your Arkansas Blue Cross and Blue Shield health insurance coverage.

Beneficiary Designation for Optional Term Life Insurance Benefits

I hereby designate the following beneficiary(ies) for the USAble Life Term Life insurance and revoke the appointment of any existing beneficiary, if making a change in beneficiary(ies). If I designate more than one beneficiary, those who survive will share equally unless specified otherwise.

The beneficiary for the Term Life insurance on a covered spouse will be the proposed insured.

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of proposed insured.)

Name (First, MI, Last)	Address	Social Security No.	Date of Birth	Relationship	Percentage Distribution		
					+		
					+		
					+		
Total must equal 100% =							

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if all primary beneficiary(ies) are not living.)

Name (First, MI, Last)	Address	Social Security No.	Date of Birth	Relationship	Percentage Distribution		
					+		
					+		
					+		
Total must equal 100% =							

20 EX	(PECTANT/AD	OPTIVE	PARENT INFORMA	TION						
☐ Yes	□ No Is any ma	ale applying	g for coverage an expectar	nt father or a p	otentia	ıl adopti	ve fath	er?		
☐ Yes	☐ No Is any female applying for coverage pregnant or a potential adoptive mother?									
If "yes,"	please provide the	following:	Name:		Expect	ed Deliv	/ery/A	doption Date: _	/	/
21 IN	FERTILITY									
Has any	applicant or spou	use of a pr	oposed applicant (wheth	er applying	for co	verage	or not) :		
		_	nosed or treated for infertilerilization? If "yes" to gues	•	nlease	nrovide	the fo	illowing:		
_ 100		Ü	Treatment/	,	•	•		J	/	/
			Treatment/							
22 TC	BACCO USA									
☐ Yes		applicant the following	to be covered used any fo	orm of tobacc	o withi	n the la	st 12 n	nonths? If "yes,"	' please	;
	Name :		Type/Amour	nt:			_ Date	Last Used:	/	/
	Name:		Type/Amour	nt:			_ Date	Last Used:	/_	/
	Name:		Type/Amour	nt:			_ Date	Last Used:	/	/
23 PF	REVIOUS INSU	IRANCE	EXPERIENCE							
☐ Yes			ever been declined, rated nsurance? If "yes," please				he issu	uance of life, ac	cident,	health
	Name:		Carrier Name:		Ye	ear:	De	tails:		
	Name:		Carrier Name:		Ye	ear:	De	tails:		
24 PF	RESCRIPTION	QUEST	IONNAIRE							
If you a	prescripti nswered "yes," p ne same informa	on medicalease provious requirements of the contraction requires the market of the contraction of the contraction requires the contraction of the	plicant currently taking a ation in the last 3 years? vide full details below. Us sested here and must b same that would have b	se separate e signed an	sheet i	if neces	sary. <i>I</i> int out	Any attachme from the pharm	nt mus nacy is	not
Person Treated	Name of Drug	Dosage	Specific Disorder or Illness	Start Date/ Stop Date		e of Rec		Complete Name and Address of Prescribing Physician		
Treateu	Of Drug		Of IIII1633	Stop Date	None	Partial	Full	Addiess of Fit	Sombling	Tilysiciali
				mo year						
				mo year						
				mo year						
				mo year						
				mo year						
				mo year						
				mo year						
				mo year						
				mo year						
				mo vear						

25 MEDICAL QUESTIONNAIRE

liver, gallbladder or rectum

■ None of the above apply to any applicant(s)

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

1. Has any applicant ever had or been told he/she had: (Each section must have at least one box checked. When multiple

	medical conditions are listed, please circ	cle	all conditions that apply.)		
	BRAIN OR NERVOUS SYSTEM DISORDERS Alzheimer's disease or senile dementia Amyotrophic lateral sclerosis (Lou Gehrig's disease) Cerebral palsy Concussion or brain injury Convulsions, epilepsy or seizures Headaches or migraines Meningitis Multiple sclerosis, muscular dystrophy or myasthenia gravis	\leftarrow	KIDNEY, URINARY, REPRODUCTIVE Abnormal pap smear Bladder or renal stones Cesarean section or miscarriage Dialysis Nephritis Nephrotic syndrome, renal disease or failure Sexually transmitted disease Sugar, blood or protein in urine Any other disorder of the kidneys or urinary tract Any other disorder of the male reproductive organs, including prostate Any other disorder of the female reproductive organs, including ovaries or breasts None of the above apply to any applicant(s)		MUSCULOSKELETAL (cont.) Fracture(s) or broken bone(s) Exposed bone ☐ Yes ☐ No Gout Lupus, systemic Temporomandibular joint disorder (TMJ/TMD or craniomandibular disorder Any other disorder of the muscles, bones or joints to include chiropractic care None of the above apply to any applicant(s EARS/EYES/NOSE/THROAT Cataracts or glaucoma Meniere's disease Nasal septal defect Sinusitis, tonsillitis or otitis media
	Any other disorder of the brain or nervous system	E.	RESPIRATORY Allergies, asthma or bronchitis Chronic pulmonary disease, emphysema, lung		Any other disorder of the eyes, ears, nose, throat or esophagus None of the above apply to any applicant(s
	CIRCULATORY Abnormal cholesterol/lipids Angina, heart attack, myocardial infarction Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty Cerebrovascular accident (stroke), including transient ischemic attack (TIA)		disease or respiratory syncytial virus (RSV) Obstructive or reactive airway disorder Sleep apnea, cpap, bipap or vpap Any other disorder of the lungs, bronchial tubes or respiratory system None of the above apply to any applicant(s)	J.	MENTAL/EMOTIONAL OR SUBSTANCE ABUSE Anxiety, insomnia, sleep disorder, depression emotional problems or nervous disorder Attempted suicide Counseling or psychiatric treatment (in-patien or out-patient)
	Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever Heart bypass surgery, pacemaker implant Heart or vein/artery surgery High blood pressure Hemophilia Valve repair/replacement	F. 00000	CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS Anemia Cancer, leukemia or malignancy of any kind Hodgkin's or Non-Hodgkin's disease Melanoma, neoplasm or tumor Any other disorder of the lymphatic system		Bipolar disorder, obsessive compulsive disorde or developmental disorder Eating disorder Any other mental, emotional disorder or situation, including ADD/ADHD None of the above apply to any applicant(s
	blood vessels or circulatory system	<u> </u>	Any other disorder of the skin None of the above apply to any applicant(s) CLANDILLAR DISORDERS		Current patient in a hospital or nursing home Pending Surgery Surgery Date:/_/_ Sarcoidosis
C.	DIGESTIVE Cirrhosis Crohn's disease or ulcerative colitis Gastric bypass surgery or other weight loss procedure	G.	GLANDULAR DISORDERS Adrenal disorders Diabetes, abnormal glucose Goiter or thyroid disease Any disorder of the pancreas None of the above apply to any applicant(s)		Breast implants Saline Silicone Surgery Date:/_/ Any other implant(s), prosthetic device(s) internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents) Acquired immune deficiency syndrome
	Hepatitis Hernia, hemorrhoids Irritable bowel syndrome or gastric esophageal reflux disorder (GERD) Pancreatitis	H	MUSCULOSKELETAL Arthritis, osteoarthritis, degenerative joint or disc disease Back pain and/or neck pain Chronic fatigue Connective tissue disorder Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other		(AIDS), or AIDS-related complex or immune deficiency disorder or HIV Transplant recipient Any injury, deformity, incapacitation, disease or condition not listed elsewhere None of the above apply to any applicant(s

☐ Fibromyalgia, bursitis or tendonitis

25 MEI	DICAL QUE	STIONNAIRE (c	ontinued)							
2. Has ar	ny applicant eve	er:								
☐ Yes			excess, received tr	eatment. or ic	ined an ord	ganization	for alc	oholis	m or dru	g addictions?
☐ Yes		No a. Consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions? No b. Used any addictive or non-addictive drug or substance for purposes other than recommended by your physician?								
☐ Yes		c. Been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider,								
	or had any indication(s) of having a drug dependency/habit?									
☐ Yes		Required the assistanc				of any acti	vities o	of daily	/ living?	If "Yes,"
		olease explain:	, 	·						·
☐ Yes	s □ No e. E	Been told that he/she h	as or has had hea	ring problem	s, ear disor	der(s) or h	as nee	ed of h	earing d	evices due
		o any kind of hearing o								
		ADD	ITIONAL ME	DICAL IN	IFORM/	AHON				
Give full of	details to ques	stions answered affire	matively (checke	d or answere	ed "Yes") t	o explain	answe	ers to	questio	ns in
SECTION	N 25. In addition	on to condition/illne	ss please provid	e the type o	f treatme	nt provide	ed or p	lanne	ed – for e	example,
surgery, >	X-rays, EKG, I	ab tests, hospitalizat	ion, emergency i	oom visit, n	ursing hon	ne confine	ement,	doct	or visits,	, rehabilitation
services,	occupational	therapy, physical the	rapy, speech the	rapy or chird	practic tre	eatments.	Pleas	e ens	ure you	include all
the treatn	nents that app	ly. Please use the n	ame that would	have been	given at t	the time o	of the	phys	ician vi	sit — e.g., a
maiden r		•								
Question	Person	Specific Disorder/III	Iness Date of	Date of	Total #	Degree o	of Docc	WARV	Cor	mplete Name
Number(s)	Treated	and Type of Treatr		Last Visit	of Visits	None P		Full		dress of Physician
TAGITIDOT(3)	Treated	and type of freati	TIOTIC THIST VISIT	Last visit	OI VISILS	None P	artiai	ruii		
				,						
			mo year	mo year	-					
			illo year	Tho year						
			mo year	mo vear	_					
			mo year	mo year						
			,	,						
			mo year	mo 'year						
			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , , , , , , , , , , , , , , ,						
			/	/						
			mo year	mo year						
				,						
			mo year	mo /year	1					
			,	,						
26 PH	YSICIAN IN	IFORMATION (PI	ease provide t	or each ar	oplicant f					
App	licant's Name	Comple	te Name and Addr	ess of Physici	ian	Date of		Reas	son	Treatment/
		'				Last Visit	[*	for Vi	SIT	Results**
							+			
							\perp			
*Dlooss ::::	O NO VICIT : #=:	in how if the applicant be-	novor coon the steer	ioion **' !	00 "Comme	to" costica	on Door	0 if	oro ross-	in pooded for datail-
riease writ	re ind vibil in thi	is box if the applicant has	never seen the phys	ician. ""U	se commen	us section (ııı rage	o II M	ore room	is needed for details.

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) This application will be medically underwritten in order to assess the potential financial risk of each individual on the application. As the result of the assessment, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, I may have particular conditions or body parts excluded, or I may be declined for coverage. I will also be subject to a 12-month pre-existing waiting period. This means conditions existing prior to the effective date of the policy will not be covered until the policy has been in effect for 12 months. If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/or offered coverage with non-medical exclusions. (2) The agent or broker involved in this insurance transaction may receive compensation from Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), or one of its affiliates, for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (3) Any coverage which may be issued to me shall be invalid if based on intentional misrepresentation of material fact provided by me on the application. (4) The COMPANY may phone me for additional information that may help with the timely processing of my application. (5) The Health insurance and Term Life insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) understand that the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request.

I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE SECTION (Ple	ease sign appropriate line only)	
Proposed Insured OR Parent/Legal Guardian's (if policy for a minor)	x	Date Signed
Spouse (required if applying)	x	Date Signed
Dependent age 18 or older (required if applying)	x	Date Signed
Dependent age 18 or older (required if applying)	x	Date Signed

CUSTODIAL PARENT SECTION

If any applicant under age 19 (primary applicant or dependent), named on this application, does NOT reside with the proposed insured or the parent/guardian indicated in Section 2, the custodial parent's signature is also required.

Custodial Parent's Name and Address (please print)	x	Telephone No.
Custodial Parent's Signature	x	Date Signed

Comments:

Pre-Authorized Bank Draft | Monthly Program Sign-up Form

Our monthly bank draft service makes premium payments easy and convenient for you. Completing this simple form helps assure your payments are made accurately and timely.

Depending on the health insurance plan you are applying for and the date your application is approved, we may be able to draft your first month's premium. If so, you will be notified in writing prior to the draft. Once the bank draft is in effect, you will not receive a billing statement.

Complete the information below.

IMPORTANT: PLEASE READ BEFORE SIGNING

I authorize Arkansas Blue Cross and Blue Shield, USAble Life, and/or the BANK indicated below, to debit my Arkansas Blue Cross and/or USAble Life premium from my checking or savings account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross and/or USAble Life coverage, UNLESS Arkansas Blue Cross and/or USAble Life has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

I understand that an	insufficient check fee will be assess	sed for any payment returned to Arkansas	Blue Cross as a result of insufficient	funds.
PROPOSED I	NSURED'S INFORMATION			
First Name:		Last Name:		
Address:				
	Street		Apt. No.	
C	City	State	Zip	
BANK ACCO	UNT INFORMATION			
	r:		osed insured) cking □ Savings	
	J. L. Webb 123 Main Street Anytown, USA 12345 PAY TO THE ORDER OF MEMO : 123456789 :	\$ DOLL 1234567890123 1175 Bank Account Number		
SIGNATURE				
Signature:	Blue Cross receives and proces	Date: nt Holder uses this completed authorization formula pope you find this bank draft service or	, you will receive a letter providing	a the
Thank you for y		For Office Use Only (please of		,
		ID NO.		

BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble

Life is solely responsible for the term life and critical illness policies referenced in your policy.

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

POLICY EFFECTIVE DATE

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 15th of the **following month** if the application is approved on the 11th - 25th of the **current month** OR the first of the month **after next** if the application is approved on the 26th - end of the **current month**. Coverage becomes effective upon the date of the policy and contingent upon receipt of premium.

Approval Date

1st - 10th 11th - 25th 26th - last day of the month

Effective Date

1st of the following month 15th of the following month 1st of the month after next

Examples

Approved Jan. 2; effective Feb. 1 Approved Jan. 12; effective Feb. 15 Approved Jan. 27; effective Mar. 1



An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 2181, Little Rock, AR 72203-2181 www.ArkansasBlueCross.com



Individual/Family Health Insurance Application

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This application is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This application must be completed in dark blue or black ink. Applications completed in pencil will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this application.
- Any **attachments** submitted with the application must be signed and dated.
- Do not send any money with this application.
- Please ensure all required parties have signed and dated the application prior to submission.
- · We strongly recommend you make a copy of this completed application for your records.

SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older.
- In "Relationship" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 8).
- If any dependents are under age 19 and do NOT reside with the proposed insured, the custodial parent must also sign the application (see *Signature Section* on Page 8).

SECTION 2 – PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

SECTION 4 – U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or green card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- · Applicants must reside in the U.S. at least one year prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

SECTION 12 – REQUESTED EFFECTIVE DATE

• The applicant should check preference for 1st or 15th of the month effective date. This is the applicant's opportunity to request the effective date coordinates with the termination of current health insurance coverage. While we cannot guarantee a specific requested effective date, we will make every effort to accommodate the request. If the application is approved, the effective date will be assigned based on the date of approval. This means retroactive effective dates will not be assigned.

SECTION 16 – TYPE OF COVERAGE

• If applicant is applying for coverage other than "Individual," please indicate if still interested in coverage if one or more applicants is declined or ineligible. If "Yes" is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If "No" is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.



IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seg., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seg. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

	This authorization must be signed by each applicant age 18 or older.								
18	Print Name(s)	Signature	Date						
Applicants age 1 and older									
ican and (
ldd\									
4									
	10.4								
	List applicants under age 18 (Print Name).								
er									
pun									
cants u age 18									
lica ag									
Applicants under age 18			1 1						
•		Parent/Legal Guardian's Signature (if policy for a minor)	Date						



Application for Health Insurance

1 WHO IS APP	LYIN	IG								
Read all instructions	s for S	Section 1 before co	mpleting] .						
First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Se	curity No.	Height	Weight
				Self					ftin.	lbs.
									ftin.	lbs.
									ftin.	lbs
									ftin.	lbs
									ftin.	lbs
									ftin.	lbs
									ftin.	lbs
2 PARENT/GU	ARD	IAN (If policy is	s only	for a child	unde	er age 19)				
Additional information	on ma	y be required. Rea	d instru	ctions for Sect	ion 2 b	efore comple	ting.			
First	Name		M.I.	Las	t Name		Re	lationship (C	heck One)	
							☐ Mother	☐ Stepmo		Guardian
2 MADITAL OT	A T 1 1 6						☐ Father	☐ Stepfat	ther	
3 MARITAL ST					<i>(</i> '	. , ,	<u>, </u>			
☐ Single (including	WIGO	wed or divorced)		☐ Married	(includ	ing separated)			
4 U.S. CITIZEN	SHIF	P STATUS								
Additional informati										
☐ Yes ☐ No Are	all ap	plicants U.S. citizen	s? If "no	," please provid	le the r	name(s) of the	applicant(s) w	ho are not l	J.S. citizens	6.
Nar	me:					Name:				
5 RESIDENTIA	LAE	DRESS (Must	be pe	rmanent ac	dres	s - No P.O.	box, pleas	se)		
Street						City		State	Zip	
								AR		
6 MAILING AD	DRE	SS (Complete	only if	different f	rom r	esidential	address)			
Street or P.O. Box						City		State	Zip	
7 BILLING ADI	DRE	SS (Complete	only if	different fr	om r	esidential a	address)			
Street or P.O. Box						City	-	State	Zip	
8 CONTACT IN	IFOF	RMATION								
Primary Phone Nur	nber	Alternate Phone N	lumber	Best Time to	- 1	E-mail /	Address		do you pre	
()		()		AM PM					nunicate wi E-mail E	In you? I Phone
9 HOUSEHOLE) INF	ORMATION								1110110
☐ Yes ☐ No a. [n the sa	me household	ዘን If "n	o " provide rea	ason and his/	her name a	and addres	ss.
		:								
		on:								
		applicants reside i	n Arkan	sas? If "no." p	rovide	reason and h	is/her name	and addres	 SS:	
		:		•						
	Reaso									
OFFICE USE O			In This	s Space)						
I.D. No.			Group I				Effective Da	ate		

10 APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]							
Name: _			Employe	· ·			
Job Duties:							
Name: _			Employe	·			
Job Dut	ies:						
11 CL	JRREN	T/	PREVIOUS INSURANCE INFORMATIO	N			
			Will the coverage applied for replace or change coverage is approved by Arkansas Blue Cross a i. If "yes," please provide name of carrier:	current hospital, medical or major medical insurance if this and Blue Shield and accepted by the applicant?			
☐ Yes	□ No		iii. If "yes," and the coverage does not have a approved by Arkansas Blue Cross and acce	specified termination date, will the coverage terminate if ented by the applicant?			
□ Yes	□ No	b. Have you recently lost employer-sponsored health coverage? If "yes," please provide: Name:Carrier Name: Termination Date:/_/					
□ Yes	□ No	No c. Have you recently "involuntarily" lost other health coverage? If "yes," please provide:					
□ Yes	□ No	Name:Carrier Name:Termination Date:// I No d. Will any applicants be continuing any other health insurance? If yes, please provide: Name:Carrier Name:ID# Name:Carrier Name:ID#					
□ Yes	□No	Name: Carrier Name: ID# □ No e. Are any applicants covered by Medicaid (other than Women's Health/Family Planning coverage)? If "yes," please provide name(s) below: Name: Name:					
□ Yes	□ No	f.	Are any applicants covered by Medicare? If "ye Name: Name:				
12 RE	EQUES	T	ED EFFECTIVE DATE				
Arkansas Blue Cross and Blue Shield gives 1 st of the month and 15 th of the month effective dates. This is your opportunity to request an effective date that coordinates with the termination of current health insurance coverage.* While we cannot guarantee a specific requested effective date, we will make every effort to accommodate the request. If your application is approved, the effective date will be assigned based on the date of approval (see back page for effective date guidelines). This means retroactive effective dates will not be assigned. Please check the day you would like your coverage to become effective:							
☐ 1 st of the month ☐ 15 th of the month ☐ No preference ☐ *Requested effective date://							
13 DRIVER'S LICENSE INFORMATION [applicant(s) age 14 and older]							
			License No. :				
				State:			
				State:			
In the past 5 years, has any applicant: ☐ Yes ☐ No a. Had his or her driver's license suspended or revoked? ☐ Yes ☐ No b. Had two or more moving traffic violations? ☐ Yes ☐ No c. Been convicted or charged with driving under the influence of alcohol or a controlled substance? ☐ If you answered "yes," to any of the above questions, you MUST provide the following information:							
Name: _			Date:	_//Violation(s):			
Name: _			Date:	_//Violation(s):			
14 SPORTING OR HOBBY INFORMATION							
☐ Yes	Yes Does any applicant intend to pilot a private aircraft; race a motor vehicle, boat or snowmobile; or participate in sky or scuba diving, ballooning, mountain climbing, hang gliding or any other hazardous sport, hobby or activity?						
Name: _				e explain:			
Name:			Please	e explain:			

15 TRAVEL OUTSIDE THE USA	
☐ Yes ☐ No Is any applicant planning to travel or work outsing ff "yes," please provide the following:	de the USA within the next two years?
Name (list all that apply):	
Country: Expected Length of Stay:	
Reason for Travel:	
16 TYPE OF COVERAGE Pead instructions for Section 16 before completing	
Read instructions for Section 16 before completing.	
☐ Individual ☐ Individual and Spouse ☐ Individual	and Child(ren) Individual, Spouse and Child(ren)
Yes No If you are applying for coverage other than one or more applicants is declined or ineligi	"Individual," do you want to continue the application process if ible?
17 BILLING MODE	
Monthly Bank Draft (Must complete attached bank draft form)	erly Semi-Annual Invoice Annual Invoice
(Mast somplete attached bank didit isim)	
18 BENEFITS SELECTION	
MUSI CHOOSE	ONE BOX ONLY
Comprehensive Blue PPO III	HSA Blue PPO II
☐ \$ 1,000 deductible	
	☐ \$ 1,500 individual/ \$ 3,000 family deductible
☐ \$ 1,500 deductible	5 3,000 family deductible
☐ \$ 2,500 deductible	
☐ \$ 5,000 deductible	¢ 2 500 is divided!/
	☐ \$ 2,500 individual/ \$ 5,000 family deductible
□ \$ 7,500 deductible	Ψ 0,000 failing deddelible
☐ \$10,000 deductible	
□ \$15,000 deductible	¢ 5 000 in divide al/
☐ \$20,000 deductible	☐ \$ 5,000 individual/ \$10,000 family deductible
	410,000 family doddonois
☐ \$25,000 deductible	
19 OPTIONAL BENEFITS SELECTION	
OPTIONAL MATERNITY BENEFITS	
Yes, I want to apply for the maternity benefits.	
	overage has been in effect for 12 months. This benefit
	ents other than a covered spouse cannot purchase the

19 OPTIONAL BENEFITS SELECTION (continued)

OPTIONAL CRITICAL ILLNESS COVERAGE

IMPORTANT NOTE: To be eligible for a Health Savings Account (HSA), you cannot be covered by insurance other than an HSA-compatible plan. Our critical illness policy should be considered "other insurance."

Underwritten and billed separately by USAble Life. USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the critical illness coverage policy referenced here.

Critical Illness Coverage is available only on the proposed insured and spouse. (Proposed insured must be 19-64 years of age.) This coverage pays a lump sum cash benefit upon the first positive diagnosis of a covered critical illness.

Choose only one of the following:
□ Proposed Insured
☐ Proposed Insured and Spouse (Spouse must also be applying for health insurance coverage on this application.)
Choose one of the following coverage amounts: ☐ \$10,000 ☐ \$20,000 ☐ \$30,000
If both the proposed insured and spouse choose Critical Illness Coverage, the coverage amounts will be the same.
Replacement: Is this insurance to replace or change other insurance? ☐ Yes ☐ No
If "yes," give details including name of company
I understand no person to be insured is also covered by any Title XIX program — Medicaid or any similar name.

OPTIONAL TERM LIFE

Underwritten by USAble Life and billed with your health insurance. USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life policy referenced here.

Term Life is available only on the proposed insured and spouse. (Proposed insured must be 19 - 64 years of age.)

Choose only one of the following:

- ☐ Proposed Insured
- ☐ Proposed Insured and Spouse (Spouse must also be applying for health insurance coverage on this application.)

Choose one of the following coverage amounts: \Box \$10,000 \Box \$30,000 \Box \$50,000

If both the proposed insured and spouse choose Term Life, the coverage amounts will be the same.

- Benefits will be paid to the designated beneficiary(ies) in one lump sum.
- Premiums are based on the age of the oldest person applying for coverage and increase when that person's age moves to
 the next age bracket. Your monthly premiums will be billed with your Arkansas Blue Cross and Blue Shield health insurance
 coverage.
- Your Term Life coverage will become effective at the same time as your Arkansas Blue Cross and Blue Shield health insurance coverage.

Beneficiary Designation for Optional Term Life Insurance Benefits

I hereby designate the following beneficiary(ies) for the USAble Life Term Life insurance and revoke the appointment of any existing beneficiary, if making a change in beneficiary(ies). If I designate more than one beneficiary, those who survive will share equally unless specified otherwise.

The beneficiary for the Term Life insurance on a covered spouse will be the proposed insured.

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of proposed insured.)

Name (First, MI, Last)	Address	Social Security No.	Date of Birth	Relationship	Percentage Distribution
					+
					+
					+
			Total must	egual 100% =	

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if all primary beneficiary(ies) are not living.)

Name (First, MI, Last)	Address	Social Security No.	Date of Birth	Relationship	Percentage Distribution
					+
					+
					+
			Total must	equal 100% =	•

20 EX	(PECTANT/AD	OPTIVE	PARENT INFORMA	TION						
☐ Yes	□ No Is any ma	☐ No Is any male applying for coverage an expectant father or a potential adoptive father?								
☐ Yes	☐ No Is any female applying for coverage pregnant or a potential adoptive mother?									
If "yes,"	please provide the	se provide the following: Name:/Expected Delivery/Adoption Date://								
21 IN	FERTILITY									
Has any	as any applicant or spouse of a proposed applicant (whether applying for coverage or not):									
		_	nosed or treated for infertilerilization? If "yes" to gues	•	nlease	nrovide	the fo	allowing:		
_ 100		Ü	Treatment/	,	•	•		J	/	/
			Treatment/							
22 TC	BACCO USA									
☐ Yes		applicant the following	to be covered used any fo	orm of tobacc	o withi	n the la	st 12 n	nonths? If "yes,"	' please	;
	Name :		Type/Amour	nt:			_ Date	Last Used:	/	/
	Name:		Type/Amour	nt:			_ Date	Last Used:	/_	/
	Name:		Type/Amour	nt:			_ Date	Last Used:	/	/
23 PF	REVIOUS INSU	IRANCE	EXPERIENCE							
☐ Yes			ever been declined, rated nsurance? If "yes," please				he issu	uance of life, ac	cident,	health
	Name:		Carrier Name:		Ye	ear:	De	tails:		
	Name:		Carrier Name:		Ye	ear:	De	tails:		
24 PF	RESCRIPTION	QUEST	IONNAIRE							
If you a	prescripti nswered "yes," p ne same informa	on medicalease provious requirements of the contraction requires the market of the contraction of the contraction requires the contraction of the	plicant currently taking a ation in the last 3 years? vide full details below. Us sested here and must b same that would have b	se separate e signed an	sheet i	if neces	sary. <i>I</i> int out	Any attachme from the pharm	nt mus nacy is	not
Person Treated	Name of Drug	Dosage	Specific Disorder or Illness	Start Date/ Stop Date		e of Rec		Complete Address of Pre		
Treateu	Of Drug		Of IIII1633	Stop Date	None	Partial	Full	Addiess of Fit	Sombling	Tilysician
				mo year						
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				mo vear						

25 MEDICAL QUESTIONNAIRE

liver, gallbladder or rectum

■ None of the above apply to any applicant(s)

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

1. Has any applicant ever had or been told he/she had: (Each section must have at least one box checked. When multiple

	medical conditions are listed, please circ	cle	all conditions that apply.)		
	BRAIN OR NERVOUS SYSTEM DISORDERS Alzheimer's disease or senile dementia Amyotrophic lateral sclerosis (Lou Gehrig's disease) Cerebral palsy Concussion or brain injury Convulsions, epilepsy or seizures Headaches or migraines Meningitis Multiple sclerosis, muscular dystrophy or myasthenia gravis	\leftarrow	KIDNEY, URINARY, REPRODUCTIVE Abnormal pap smear Bladder or renal stones Cesarean section or miscarriage Dialysis Nephritis Nephrotic syndrome, renal disease or failure Sexually transmitted disease Sugar, blood or protein in urine Any other disorder of the kidneys or urinary tract Any other disorder of the male reproductive organs, including prostate Any other disorder of the female reproductive organs, including ovaries or breasts None of the above apply to any applicant(s)		MUSCULOSKELETAL (cont.) Fracture(s) or broken bone(s) Exposed bone ☐ Yes ☐ No Gout Lupus, systemic Temporomandibular joint disorder (TMJ/TMD or craniomandibular disorder Any other disorder of the muscles, bones or joints to include chiropractic care None of the above apply to any applicant(s EARS/EYES/NOSE/THROAT Cataracts or glaucoma Meniere's disease Nasal septal defect Sinusitis, tonsillitis or otitis media
	Any other disorder of the brain or nervous system	E.	RESPIRATORY Allergies, asthma or bronchitis Chronic pulmonary disease, emphysema, lung		Any other disorder of the eyes, ears, nose, throat or esophagus None of the above apply to any applicant(s
	CIRCULATORY Abnormal cholesterol/lipids Angina, heart attack, myocardial infarction Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty Cerebrovascular accident (stroke), including transient ischemic attack (TIA)		disease or respiratory syncytial virus (RSV) Obstructive or reactive airway disorder Sleep apnea, cpap, bipap or vpap Any other disorder of the lungs, bronchial tubes or respiratory system None of the above apply to any applicant(s)	J.	MENTAL/EMOTIONAL OR SUBSTANCE ABUSE Anxiety, insomnia, sleep disorder, depression emotional problems or nervous disorder Attempted suicide Counseling or psychiatric treatment (in-patien or out-patient)
	Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever Heart bypass surgery, pacemaker implant Heart or vein/artery surgery High blood pressure Hemophilia Valve repair/replacement	F. 00000	CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS Anemia Cancer, leukemia or malignancy of any kind Hodgkin's or Non-Hodgkin's disease Melanoma, neoplasm or tumor Any other disorder of the lymphatic system		Bipolar disorder, obsessive compulsive disorde or developmental disorder Eating disorder Any other mental, emotional disorder or situation, including ADD/ADHD None of the above apply to any applicant(s
	blood vessels or circulatory system	<u> </u>	Any other disorder of the skin None of the above apply to any applicant(s) CLANDILLAR DISORDERS		Current patient in a hospital or nursing home Pending Surgery Surgery Date:/_/_ Sarcoidosis
C.	DIGESTIVE Cirrhosis Crohn's disease or ulcerative colitis Gastric bypass surgery or other weight loss procedure	G.	GLANDULAR DISORDERS Adrenal disorders Diabetes, abnormal glucose Goiter or thyroid disease Any disorder of the pancreas None of the above apply to any applicant(s)		Breast implants Saline Silicone Surgery Date:/_/ Any other implant(s), prosthetic device(s) internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents) Acquired immune deficiency syndrome
	Hepatitis Hernia, hemorrhoids Irritable bowel syndrome or gastric esophageal reflux disorder (GERD) Pancreatitis	H	MUSCULOSKELETAL Arthritis, osteoarthritis, degenerative joint or disc disease Back pain and/or neck pain Chronic fatigue Connective tissue disorder Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other		(AIDS), or AIDS-related complex or immune deficiency disorder or HIV Transplant recipient Any injury, deformity, incapacitation, disease or condition not listed elsewhere None of the above apply to any applicant(s

☐ Fibromyalgia, bursitis or tendonitis

25 MEI	DICAL QUE	STIONNAIRE (c	ontinued)							
2. Has ar	ny applicant eve	er:								
☐ Yes		Consumed alcohol to e	excess, received tr	eatment. or ic	ined an ord	ganization	for alc	oholis	m or dru	g addictions?
☐ Yes		Jsed any addictive or r								
☐ Yes		Been treated for, diagno								
		or had any indication(s)							,	provider,
☐ Yes		Required the assistanc				of any acti	vities o	of daily	/ living?	If "Yes,"
		olease explain:	, 	·		,				·
☐ Yes	s □ No e. E	Been told that he/she h	as or has had hea	ring problem	s, ear disor	der(s) or h	as nee	ed of h	earing d	evices due
		o any kind of hearing o								
		ADD	ITIONAL ME	DICAL IN	IFORM/	AHON				
Give full of	details to ques	stions answered affire	matively (checke	d or answere	ed "Yes") t	o explain	answe	ers to	questio	ns in
SECTION	N 25. In addition	on to condition/illne	ss please provid	e the type o	f treatme	nt provide	ed or p	lanne	ed – for e	example,
surgery, >	X-rays, EKG, I	ab tests, hospitalizat	ion, emergency i	oom visit, n	ursing hon	ne confine	ement,	doct	or visits,	, rehabilitation
services,	occupational	therapy, physical the	rapy, speech the	rapy or chird	practic tre	eatments.	Pleas	e ens	ure you	include all
the treatn	nents that app	ly. Please use the n	ame that would	have been	given at t	the time o	of the	phys	ician vi	sit — e.g., a
maiden r		•								
Question	Person	Specific Disorder/III	Iness Date of	Date of	Total #	Degree o	of Docc	WARV	Cor	mplete Name
Number(s)	Treated	and Type of Treatr		Last Visit	of Visits	None P		Full		dress of Physician
Tauriber(3)	Treated	and type of freati	TICHE THE VIOLE	Last visit	OI VISILS	None P	artiai	ruii		
				,						
			mo year	mo year	-					
			illo year	Tho year						
			mo year	mo vear	_					
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			mo year	mo year						
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			mo year	mo /year	1					
			,	,						
26 PH	YSICIAN IN	IFORMATION (PI	ease provide t	or each ar	oplicant f					
App	licant's Name	Comple	te Name and Addr	ess of Physici	ian	Date of		Reas	son	Treatment/
		'				Last Visit	[*	for Vi	SIT	Results**
							+			
							\perp			
*Dlooss ::::	O NO VICIT : #=:	in how if the applicant be-	novor coon the steer	ioion **' !	00 "Comme	to" costica	on Door	0 if	oro ross-	in pooded for datail-
riease writ	re ind vibil in thi	is box if the applicant has	never seen the phys	ician. ""U	se commen	us section (ııı rage	o II M	ore room	is needed for details.

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) This application will be medically underwritten in order to assess the potential financial risk of each individual on the application. As the result of the assessment, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, I may have particular conditions or body parts excluded, or I may be declined for coverage. I will also be subject to a 12-month pre-existing waiting period. This means conditions existing prior to the effective date of the policy will not be covered until the policy has been in effect for 12 months. If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/or offered coverage with non-medical exclusions. (2) The agent or broker involved in this insurance transaction may receive compensation from Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), or one of its affiliates, for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (3) Any coverage which may be issued to me shall be invalid if based on intentional misrepresentation of material fact provided by me on the application. (4) The COMPANY may phone me for additional information that may help with the timely processing of my application. (5) The Health insurance and Term Life insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) understand that the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request.

I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE SECTION (Ple	ease sign appropriate line only)	
Proposed Insured OR Parent/Legal Guardian's (if policy for a minor)	x	Date Signed
Spouse (required if applying)	x	Date Signed
Dependent age 18 or older (required if applying)	x	Date Signed
Dependent age 18 or older (required if applying)	x	Date Signed

CUSTODIAL PARENT SECTION

If any applicant under age 19 (primary applicant or dependent), named on this application, does NOT reside with the proposed insured or the parent/guardian indicated in Section 2, the custodial parent's signature is also required.

Custodial Parent's Name and Address (please print)	x	Telephone No.
Custodial Parent's Signature	x	Date Signed

Comments:

Pre-Authorized Bank Draft | Monthly Program Sign-up Form

Our monthly bank draft service makes premium payments easy and convenient for you. Completing this simple form helps assure your payments are made accurately and timely.

Depending on the health insurance plan you are applying for and the date your application is approved, we may be able to draft your first month's premium. If so, you will be notified in writing prior to the draft. Once the bank draft is in effect, you will not receive a billing statement.

Complete the information below.

IMPORTANT: PLEASE READ BEFORE SIGNING

I authorize Arkansas Blue Cross and Blue Shield, USAble Life, and/or the BANK indicated below, to debit my Arkansas Blue Cross and/or USAble Life premium from my checking or savings account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross and/or USAble Life coverage, UNLESS Arkansas Blue Cross and/or USAble Life has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

I understand that an	insufficient check fee will be assess	sed for any payment returned to Arkansas	Blue Cross as a result of insufficient	funds.
PROPOSED I	NSURED'S INFORMATION			
First Name:		Last Name:		
Address:				
	Street		Apt. No.	
C	City	State	Zip	
BANK ACCO	UNT INFORMATION			
	r:		osed insured) cking □ Savings	
	J. L. Webb 123 Main Street Anytown, USA 12345 PAY TO THE ORDER OF MEMO : 123456789 :	\$ DOLL 1234567890123 1175 Bank Account Number		
SIGNATURE				
Signature:	Blue Cross receives and proces	Date: nt Holder uses this completed authorization formula pope you find this bank draft service or	, you will receive a letter providing	a the
Thank you for y		For Office Use Only (please of		,
		ID NO.		

BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble

Life is solely responsible for the term life and critical illness policies referenced in your policy.

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

POLICY EFFECTIVE DATE

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 15th of the **following month** if the application is approved on the 11th - 25th of the **current month** OR the first of the month **after next** if the application is approved on the 26th - end of the **current month**. Coverage becomes effective upon the date of the policy and contingent upon receipt of premium.

Approval Date

1st - 10th 11th - 25th 26th - last day of the month

Effective Date

1st of the following month 15th of the following month 1st of the month after next

Examples

Approved Jan. 2; effective Feb. 1 Approved Jan. 12; effective Feb. 15 Approved Jan. 27; effective Mar. 1



An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 2181, Little Rock, AR 72203-2181 www.ArkansasBlueCross.com



Individual/Family Health Insurance Application

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This application is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This application must be completed in dark blue or black ink. Applications completed in pencil will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this application.
- Any **attachments** submitted with the application must be signed and dated.
- Do not send any money with this application.
- Please ensure all required parties have signed and dated the application prior to submission.
- · We strongly recommend you make a copy of this completed application for your records.

SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older.
- In "Relationship" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 8).
- If any dependents are under age 19 and do NOT reside with the proposed insured, the custodial parent must also sign the application (see *Signature Section* on Page 8).

SECTION 2 – PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

SECTION 4 – U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or green card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- · Applicants must reside in the U.S. at least one year prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

SECTION 12 – REQUESTED EFFECTIVE DATE

• The applicant should check preference for 1st or 15th of the month effective date. This is the applicant's opportunity to request the effective date coordinates with the termination of current health insurance coverage. While we cannot guarantee a specific requested effective date, we will make every effort to accommodate the request. If the application is approved, the effective date will be assigned based on the date of approval. This means retroactive effective dates will not be assigned.

SECTION 16 – TYPE OF COVERAGE

• If applicant is applying for coverage other than "Individual," please indicate if still interested in coverage if one or more applicants is declined or ineligible. If "Yes" is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If "No" is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.





IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seg., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seg. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

	This authorization must be signed by each ap	plicant age 18 or older.	
18	Print Name(s)	Signature	Date
Applicants age and older			
ican			
ildd 8			
٩			
	List applicants under age 18 (Print Name).		
	List applicants under age 10 (1 fint Name).		
der			
nuc 8			
Applicants under age 18			
plica ag			
Ар			
		Parent/Legal Guardian's Signature (if policy for a minor)	Date



Application for Health Insurance

For Arkansas Blue Cross Use Only					
	This applica	ition was re	eceived by:		
□С	□NW	□ NE	□ WC		
□sc	□ SW	☐ SE	☐ Customer		
☐ Reta	il Store		Service		
Date Star	mp				

An Independent Licensee of the Blue Cross	and Blue Sh	ield Association								
1 WHO IS APP										
Read all instructions	for S	Section 1 before cor	npleting].						
First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Se	curity No.	Height	Weight
	+			Self					ft. in.	lbs
	\Box								ft. in.	lbs
									ftin.	lbs
									ftin.	lbs
									ftin.	lbs
									ftin.	lbs
_									ftin.	lbs
2 PARENT/GU										
Additional information	n ma	y be required. Rea	d instru	ctions for Secti	on 2 b	efore complet	ing.			
First	Name		M.I.	Last	Name		Re	elationship (C	heck One)	
							☐ Mother ☐ Father	☐ Stepmo		Guardiar
3 MARITAL STA	ATHS	3					□ Father	□ Stepiat	ner	
☐ Single (including				□ Married (i	includ	ing separated)				
				□ Marrica (i	iliciaa	ing separated)				
4 U.S. CITIZEN			-1 -1 1	ations for Oast	4 1					
Additional information ☐ Yes ☐ No Are		•					•	the are not l	I S citizona	
		plicarits 0.5. Citizers	5: II 110	, piease provide		, ,	ipplical It(s) v	nio are not c	7.5. GILIZEITE	o.
Nar		NDDEOG (M. 4				Name:				
5 RESIDENTIA Street	L AL	DRESS (Must	pe pe	rmanent ad	ares	S - NO P.O. City	box, piea	se) State	Zip	
Olicci						Oity		AR	ΖΙΡ	
6 MAILING ADI	DRE	SS (Complete o	only if	different fr	om r	esidential a	address)	7 (1)		
Street or P.O. Box		ee (eempiete	only n	amorone n	J	City	iaai ooo,	State	Zip	
						,			·	
7 BILLING ADI)RE	SS (Complete o	nly if	different fr	om r	esidential a	ddrass)			
Street or P.O. Box		oo (oompiete t	illy ii	unierent m		City	iddi ess _j	State	Zip	
000.0						O.1.)				
8 CONTACT IN	FOR	MATION								
Primary Phone Nun			umber	Best Time to	Call	E-mail A	ddress		lo you pre	
()		()		AM PM					unicate wi -mail E	th you? Phone
0 HOUSEHOLF	INIE	ODMATION							-IIIaII L	riione
9 HOUSEHOLD ☐ Yes ☐ No a. D			the sa	me household	2 If "n	n " provide rea	son and his	/her name a	and address	
						•				
		n:			<i>'</i>			0 8 8 8 8 8 9 9 9		
☐ Yes ☐ No b. □				 sas? If "no," pr	ovide	reason and hi	s/her name	and addres	s:	
	Reaso									
OFFICE USE O	NLY	(Do Not Write I	n This	s Space)						
I.D. No.			Group N				Effective D	ate		

10 APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]								
Name: _			Empl	oloyer:				
Job Dut	ies:							
Name: _			Empl	oloyer:				
Job Dut	ies:							
11 CL	JRREN	JT/	PREVIOUS INSURANCE INFORMA	TION				
			Will the coverage applied for replace or cha coverage is approved by Arkansas Blue Cro i. If "yes," please provide name of carrier	ange current hospital, medical or major medical insoss and Blue Shield and accepted by the applican	t?			
☐ Yes	□ No		•	ve a specified termination date, will the coverage				
□ Yes	□ No	b.	Have you recently lost employer-sponsored		1 1			
□ Yes	□ No	C.	Have you recently "involuntarily" lost other h	health coverage? If "yes," please provide: e: Termination Date:				
☐ Yes	□ No	d.	Will any applicants be continuing any othe Name: Carrier Name:					
□ Yes	□ No	e.	Are any applicants covered by Medicaid (oth please provide name(s) below: Name: Name:	ther than Women's Health/Family Planning covera	ge)? If "yes,"			
□ Yes	□ No	f.	Are any applicants covered by Medicare? In Name: Name:					
12 RF	OUES	ìΤ:	ED EFFECTIVE DATE					
Arkansa an effec requesto will be a	as Blue (tive date ed effect assigned	Cro e th tive	ss and Blue Shield gives 1st of the month and 1 at coordinates with the termination of current be date, we will make every effort to accommod	15th of the month effective dates. This is your opport health insurance coverage.* While we cannot guardate the request. If your application is approved, the for effective date guidelines). This means retrollike your coverage to become effective:	antee a specific e effective date			
	1 st of the	e m	onth ☐ 15 th of the month ☐ No prefe	erence	_/			
13 DF	RIVER	'S	LICENSE INFORMATION [applicant	t(s) age 14 and older]				
			License No					
				o.: State:				
				o.: State:				
☐ Yes ☐ Yes	□ No	a. b. c.		r revoked? er the influence of alcohol or a controlled substancuestions, you MUST provide the following informa				
Name: _			Date:	/Violation(s):				
Name: _			Date: .	// Violation(s):	· · · · · · · · · · · · · · · · · · ·			
			OR HOBBY INFORMATION					
☐ Yes	□ No	ра	es any applicant intend to pilot a private airc rticipate in sky or scuba diving, ballooning, m zardous sport, hobby or activity?	craft; race a motor vehicle, boat or snowmobile; or nountain climbing, hang gliding or any other				
Name: _			PI	lease explain:				
Name:			PI	lease explain:				

15 TRAVEL OUTSIDE THE USA	
☐ Yes ☐ No Is any applicant planning to travel or work outsi If "yes," please provide the following:	de the USA within the next two years?
Name (list all that apply):	
Country: Expected Length of Stay: Reason for Travel:	
16 TYPE OF COVERAGE	
Read instructions for Section 16 before completing.	
☐ Individual ☐ Individual and Spouse ☐ Individual	and Child(ren) Individual, Spouse and Child(ren)
Yes No If you are applying for coverage other than one or more applicants is declined or ineligi	"Individual," do you want to continue the application process if ble?
17 BILLING MODE	
☐ Monthly ☐ Quarter ☐ Invoic	erly Semi-Annual Annual
☐ Bank Draft ☐ Invoic (Must complete attached bank draft form)	e Invoice Invoice
MUST CHOOSE	ONE BOX ONLY
Comprehensive Blue PPO III	HSA Blue PPO II
□ \$ 1,000 deductible	\$ 1.500 individual/
☐ \$ 1,500 deductible	□ \$ 1,500 individual/ \$ 3,000 family deductible
•	· · · · · · · · · · · · · · · · · · ·
□ \$ 2,500 deductible	
☐ \$ 5,000 deductible	☐ \$ 2,500 individual/ \$ 5,000 family deductible
☐ \$ 7,500 deductible	☐ \$ 5,000 family deductible
☐ \$10,000 deductible	
☐ \$15,000 deductible	
	<pre>\$ 5,000 individual/ \$10,000 family deductible</pre>
□ \$20,000 deductible	— \$10,000 family deductible
☐ \$25,000 deductible	
19 OPTIONAL BENEFITS SELECTION	
OPTIONAL MATERNITY BENEFITS	
Yes, I want to apply for the maternity benefits.	
	overage has been in effect for 12 months. This benefit ents other than a covered spouse cannot purchase the

19 OPTIONAL BENEFITS SELECTION (continued)

OPTIONAL CRITICAL ILLNESS COVERAGE

IMPORTANT NOTE: To be eligible for a Health Savings Account (HSA), you cannot be covered by insurance other than an HSA-compatible plan. Our critical illness policy should be considered "other insurance."

Underwritten and billed separately by USAble Life. USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the critical illness coverage policy referenced here.

Critical Illness Coverage is available only on the proposed insured and spouse. (Proposed insured must be 19-64 years of age.) This coverage pays a lump sum cash benefit upon the first positive diagnosis of a covered critical illness.

Choose only one of the following:									
□ Proposed Insured									
☐ Proposed Insured and Spouse (Spouse must also be applying for health insurance coverage on this application.)									
Choose one of the following coverage amounts: ☐ \$10,000 ☐ \$20,000 ☐ \$30,000									
If both the proposed insured and spouse choose Critical Illness Coverage, the coverage amounts will be the same.									
Replacement: Is this insurance to replace or change other insurance? ☐ Yes ☐ No									
If "yes," give details including name of company									
I understand no person to be insured is also covered by any Title XIX program — Medicaid or any similar name.									

OPTIONAL TERM LIFE

Underwritten by USAble Life and billed with your health insurance. USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life policy referenced here.

Term Life is available only on the proposed insured and spouse. (Proposed insured must be 19 - 64 years of age.)

Choose only one of the following:

☐ Proposed Insured and Spouse (Spouse must also be applying for health insurance coverage on this application.)

Choose one of the following coverage amounts: $\Box $10,000$ $\Box $30,000$ $\Box $50,000$

If both the proposed insured and spouse choose Term Life, the coverage amounts will be the same.

- Benefits will be paid to the designated beneficiary(ies) in one lump sum.
- Premiums are based on the age of the oldest person applying for coverage and increase when that person's age moves to
 the next age bracket. Your monthly premiums will be billed with your Arkansas Blue Cross and Blue Shield health insurance
 coverage.
- Your Term Life coverage will become effective at the same time as your Arkansas Blue Cross and Blue Shield health insurance coverage.

Beneficiary Designation for Optional Term Life Insurance Benefits

I hereby designate the following beneficiary(ies) for the USAble Life Term Life insurance and revoke the appointment of any existing beneficiary, if making a change in beneficiary(ies). If I designate more than one beneficiary, those who survive will share equally unless specified otherwise.

The beneficiary for the Term Life insurance on a covered spouse will be the proposed insured.

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of proposed insured.)

Name (First, MI, Last)	Address	Social Security No.	Date of Birth	Relationship	Percentage Distribution				
					+				
					+				
					+				
Total must equal 100% =									

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if all primary beneficiary(ies) are not living.)

Name (First, MI, Last)	Address	Social Security No.	Date of Birth	Relationship	Percentage Distribution				
					+				
					+				
					+				
Total must equal 100% =									

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20 EX	(PECTANT/AD	OPTIVE	PARENT INFORMA	TION						
☐ Yes	□ No Is any ma	ale applying	g for coverage an expectar	nt father or a p	otentia	ıl adopti	ve fath	er?		
☐ Yes	☐ No Is any fer	nale apply	ing for coverage pregnant	or a potential	adoptiv	e mothe	er?			
If "yes,"	please provide the	following:	Name:		Expect	ed Deliv	/ery/A	doption Date: _	/	/
21 IN	FERTILITY									
Has any	applicant or spou	use of a pr	oposed applicant (wheth	er applying	for co	verage	or not) :		
		_	nosed or treated for infertilerilization? If "yes" to gues	•	nlease	nrovide	the fo	allowing:		
_ 100		Ü	Treatment/	,	•	•		J	/	/
			Treatment/							
22 TC	BACCO USA									
☐ Yes		applicant the following	to be covered used any fo	orm of tobacc	o withi	n the la	st 12 n	nonths? If "yes,"	' please	;
	Name :		Type/Amour	nt:			_ Date	Last Used:	/	/
	Name:		Type/Amour	nt:			_ Date	Last Used:	/_	/
	Name:		Type/Amour	nt:			_ Date	Last Used:	/	/
23 PF	REVIOUS INSU	IRANCE	EXPERIENCE							
☐ Yes			ever been declined, rated nsurance? If "yes," please				he issu	uance of life, ac	cident,	health
	Name:		Carrier Name:		Ye	ear:	De	tails:		
	Name:		Carrier Name:		Ye	ear:	De	tails:		
24 PF	RESCRIPTION	QUEST	IONNAIRE							
If you a	prescripti nswered "yes," p ne same informa	on medicalease provious requirements of the contraction requires the market of the contraction of the contraction requires the contraction of the	plicant currently taking a ation in the last 3 years? vide full details below. Us sested here and must b same that would have b	se separate e signed an	sheet i	if neces	sary. <i>I</i> int out	Any attachme from the pharm	nt mus nacy is	not
Person Treated	Name of Drug	Dosage	Specific Disorder or Illness	Start Date/ Stop Date		e of Rec		Complete Address of Pre		
Treateu	Of Drug		Of IIII1633	Stop Date	None	Partial	Full	Addiess of Fit	Sombling	Tilysician
				mo year						
				mo year						
				mo year						
				mo year						
				mo year						
				mo year						
				mo year						
				mo year						
				mo year						
				mo vear						

25 MEDICAL QUESTIONNAIRE

liver, gallbladder or rectum

■ None of the above apply to any applicant(s)

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

1. Has any applicant ever had or been told he/she had: (Each section must have at least one box checked. When multiple

medical conditions are listed, please circ	cle	all conditions that apply.)		•
BRAIN OR NERVOUS SYSTEM DISORDERS Alzheimer's disease or senile dementia Amyotrophic lateral sclerosis (Lou Gehrig's disease) Cerebral palsy Concussion or brain injury Convulsions, epilepsy or seizures Headaches or migraines Meningitis Multiple sclerosis, muscular dystrophy or myasthenia gravis	D .	Abnormal pap smear Bladder or renal stones Cesarean section or miscarriage Dialysis Nephritis Nephrotic syndrome, renal disease or failure Sexually transmitted disease Sugar, blood or protein in urine Any other disorder of the kidneys or urinary tract		MUSCULOSKELETAL (cont.) Fracture(s) or broken bone(s) Exposed bone ☐ Yes ☐ No Gout Lupus, systemic Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder Any other disorder of the muscles, bones or joints to include chiropractic care None of the above apply to any applicant(s)
Neuritis Paralysis or palsy Parkinson's disease Polyneuritis Vertigo, fainting or dizziness Any other disorder of the brain or nervous system None of the above apply to any applicant(s)		Any other disorder of the male reproductive organs, including prostate Any other disorder of the female reproductive organs, including ovaries or breasts None of the above apply to any applicant(s) RESPIRATORY Allergies, asthma or bronchitis	I. 0 0 0 0 0	Meniere's disease Nasal septal defect Sinusitis, tonsillitis or otitis media Any other disorder of the eyes, ears, nose, throat or esophagus
CIRCULATORY Abnormal cholesterol/lipids Angina, heart attack, myocardial infarction Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty Cerebrovascular accident (stroke), including transient ischemic attack (TIA)		Chronic pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV) Obstructive or reactive airway disorder Sleep apnea, cpap, bipap or vpap Any other disorder of the lungs, bronchial tubes or respiratory system None of the above apply to any applicant(s)	J.	MENTAL/EMOTIONAL OR SUBSTANCE ABUSE Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder Attempted suicide Counseling or psychiatric treatment (in-patient or out-patient)
Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever Heart bypass surgery, pacemaker implant Heart or vein/artery surgery High blood pressure Hemophilia Valve repair/replacement	F. 0000	CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS Anemia Cancer, leukemia or malignancy of any kind Hodgkin's or Non-Hodgkin's disease Melanoma, neoplasm or tumor Any other disorder of the lymphatic system	_	Bipolar disorder, obsessive compulsive disorder or developmental disorder Eating disorder Any other mental, emotional disorder or situation, including ADD/ADHD None of the above apply to any applicant(s)
Any other disorder of the heart, blood, blood vessels or circulatory system None of the above apply to any applicant(s)		Any other disorder of the skin None of the above apply to any applicant(s)		OTHER Current patient in a hospital or nursing home Pending Surgery Surgery Date:/_/ Sarcoidosis
DIGESTIVE Cirrhosis Crohn's disease or ulcerative colitis Gastric bypass surgery or other weight loss procedure	G	GLANDULAR DISORDERS Adrenal disorders Diabetes, abnormal glucose Goiter or thyroid disease Any disorder of the pancreas None of the above apply to any applicant(s)		
Gastric or duodenal ulcer Hepatitis Hernia, hemorrhoids Irritable bowel syndrome or gastric esophageal reflux disorder (GERD) Pancreatitis Pyloric stenosis Any other disorder of stomach, intestines,	H	MUSCULOSKELETAL Arthritis, osteoarthritis, degenerative joint or disc disease Back pain and/or neck pain Chronic fatigue Connective tissue disorder Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other		(AIDS), or AIDS-related complex or immune deficiency disorder or HIV Transplant recipient Any injury, deformity, incapacitation, disease or condition not listed elsewhere None of the above apply to any applicant(s)

☐ Fibromyalgia, bursitis or tendonitis

25 MEI	DICAL QU	JESTI	ONNAIRE (contir	nued)									
2. Has ar	ny applicant e	ever:											
☐ Yes			imed alcohol to excess	, received t	reatme	nt, or jo	oined an org	ganizatio	n for alc	coholis	m or dru	g addictions?	
☐ Yes						_	_					-	1?
☐ Yes	☐ Yes ☐ No b. Used any addictive or non-addictive drug or substance for purposes other than recommended by your physician? ☐ Yes ☐ No c. Been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider,												
			any indication(s) of ha					• •			,		
☐ Yes	☐ Yes ☐ No d. Required the assistance of any other individual for performances of any activities of daily living? If "Yes," please explain:												
☐ Yes	☐ Yes ☐ No e. Been told that he/she has or has had hearing problems, ear disorder(s) or has need of hearing devices due												
to any kind of hearing or ear impairment, or does any applicant have an existing hearing aid device in place? ADDITIONAL MEDICAL INFORMATION													
Give full details to questions answered affirmatively (checked or answered "Yes") to explain answers to questions in													
SECTION	V 25. In addi	ition to	condition/illness ple	ease provi	de the	type o	of treatme	nt provi	ded or p	olanne	ed – for	example,	
surgery, >	K-rays, EKG	i, lab te	sts, hospitalization, e	mergency	room	visit, n	ursing hon	ne confi	nement	, doct	or visits	, rehabilitation	
services,	occupationa	al thera	py, physical therapy,	speech th	erapy o	or chire	opractic tre	atment	s. Pleas	se ens	ure you	include all	
the treatn	nents that a	pply. Pl	ease use the name	that woul	d have	been	given at t	he time	of the	phys	ician vi	sit — e.g., a	
maiden r	name.												
Question	Person	Sr	pecific Disorder/Illness	Date of	Dat	e of	Total #	Degree	e of Rec	overv	Co	mplete Name	
Number(s)	Treated		nd Type of Treatment	First Visi		Visit	of Visits		Partial			dress of Physicia	an
			71					140110	1 ditial	ı un			
				1		1							
				mo 'year	mo	' <u>year</u>							
				,									
				1		1							
				mo year	mo	year							
				/	_	1	_						
				mo year	mo	year							
				1		1							
				mo year	mo	year	-						
				,									
				/////	mo	/							
				mo year		year							
26 PH	YSICIAN	INFOF	RMATION (Please	provide	for ea	ich a	oplicant f	or the	last fiv	ve ye	ars)		
	licant's Name		Complete Nan					Date	of	Reas	son	Treatment/	
, , , , ,			Complete Han	TIO GITO TIGO	1000 01	1 119010		Last Vi	sit*	for Vi	sit**	Results**	

*Please write **NO VISIT** in this box if the applicant has never seen the physician.

^{**}Use "Comments" section on Page 8 if more room is needed for details.

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) This application will be medically underwritten in order to assess the potential financial risk of each individual on the application. As the result of the assessment, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, I may have particular conditions or body parts excluded, or I may be declined for coverage. I will also be subject to a 12-month pre-existing waiting period. This means conditions existing prior to the effective date of the policy will not be covered until the policy has been in effect for 12 months. If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/or offered coverage with non-medical exclusions. (2) The agent or broker involved in this insurance transaction may receive compensation from Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), or one of its affiliates, for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (3) Any coverage which may be issued to me shall be invalid if based on intentional misrepresentation of material fact provided by me on the application. (4) The COMPANY may phone me for additional information that may help with the timely processing of my application. (5) The Health insurance and Term Life insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) understand that the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request.

I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE SECTION (PIE	ease sign appropriate line only)	
Proposed Insured OR Parent/Legal Guardian's		Date Signed
(if policy for a minor)	X	
Spouse		Date Signed
(required if applying)	X	
Dependent age 18 or older (required if applying)	x	Date Signed
Dependent age 18 or older		Date Signed
(required if applying)	x	
CUSTODIAL PARENT SEC	TION	
	(primary applicant or dependent), named on this application, does rent/guardian indicated in Section 2, the <mark>custodial parent's</mark> signatu	
Custodial Parent's Name and Address (please print)	x	Telephone No.
Custodial Parent's		Date Signed
Signature	X	
This section to be complet	ed by sales representative	
	wledge, will the coverage applied for replace or change any existing hospit iis coverage is approved by Arkansas Blue Cross and Blue Shield and acc	
Sales Rep License No.	Sales Representative's Name (Please Print)	Telephone No.
(required)	X	
Agency Federal Tax ID No.	Sales Representative's Signature	Date Signed
(If applicable)	X	
Comments:		

Pre-Authorized Bank Draft | Monthly Program Sign-up Form

Our monthly bank draft service makes premium payments easy and convenient for you. Completing this simple form helps assure your payments are made accurately and timely.

Depending on the health insurance plan you are applying for and the date your application is approved, we may be able to draft your first month's premium. If so, you will be notified in writing prior to the draft. Once the bank draft is in effect, you will not receive a billing statement.

Complete the information below.

IMPORTANT: PLEASE READ BEFORE SIGNING

I authorize Arkansas Blue Cross and Blue Shield, USAble Life, and/or the BANK indicated below, to debit my Arkansas Blue Cross and/or USAble Life premium from my checking or savings account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross and/or USAble Life coverage, UNLESS Arkansas Blue Cross and/or USAble Life has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

PROPOSED INSURED'S INFORMATION First Name:	I understand that an	insufficient check fee will be assess	sed for any payment returned to Arkansas	Blue Cross as a result of insufficie	nt funds.
Address: Street	PROPOSED I	NSURED'S INFORMATION			
Street City State Zip BANK ACCOUNT INFORMATION Bank Name: Name on Account: (If different than the proposed insured) Account Number: Type of Account: Checking Savings 1.L. Webb 123 Main Street Anytown, USA 12345 PAY TO THE	First Name:		Last Name:		
BANK ACCOUNT INFORMATION Bank Name:	Address:				
Bank Name: Name on Account: (If different than the proposed insured) Routing Number: Account Number: Type of Account: Checking Savings	S	Street		Apt. No.	
Bank Name: Name on Account: (If different than the proposed insured) Account Number: Type of Account: Checking Savings 1, L. Webb 123 Main Street Anytown, USA 12345 PAY TO THE S ODLIARS DOLIARS DOLIARS DOLIARS DOLIARS Bank Routing Number Bank Account Number Check Number		,	State	Zip	
Routing Number: Type of Account: Type of Accou	BANK ACCOL	JNT INFORMATION			
123 Main Street Anytown, USA 12345 PAY TO THE ORDER OF DOLLARS MEMO : 123456789 : 1234567890123 1175 Bank Routing Number Bank Account Number Check Number SIGNATURE					
		123 Main Street Anytown, USA 12345 PAY TO THE ORDER OF MEMO : 123456789 :	\$ DOL 1234567890123 1175	LARS	
Signature: Date: Date:	SIGNATURE				
After Arkansas Blue Cross receives and processes this completed authorization form, you will receive a letter providing the	-	_			
effective date of your first scheduled draft. We hope you find this bank draft service of value. It is our privilege to serve you.	effective date of	your first scheduled draft. We h	nope you find this bank draft service o	of value. It is our privilege to serv	ve you.
For Office Use Only (please do not write in this space) ID NO. EFFECTIVE DATE		oui publilebb!			

Form No. U-65 APP IA (R01/12)

BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield, USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products, USAble

Life is solely responsible for the term life and critical illness policies referenced in your policy.

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

POLICY EFFECTIVE DATE

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 15th of the **following month** if the application is approved on the 11th - 25th of the **current month** OR the first of the month **after next** if the application is approved on the 26th - end of the **current month**. Coverage becomes effective upon the date of the policy and contingent upon receipt of premium.

Approval Date

1st - 10th 11th - 25th 26th - last day of the month

Effective Date

1st of the following month 15th of the following month 1st of the month after next

Examples

Approved Jan. 2; effective Feb. 1 Approved Jan. 12; effective Feb. 15 Approved Jan. 27; effective Mar. 1



An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 2181, Little Rock, AR 72203-2181 www.ArkansasBlueCross.com



List Bill Individual/Family Health Insurance Application

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This application is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information
 provided must be accurate and legible.
- This application must be completed in dark blue or black ink. Applications completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this application.
- Any **attachments** submitted with the application must be signed and dated.
- Do not send any money with this application.
- Please ensure all required parties have signed and dated the application prior to submission.
- · We strongly recommend you make a copy of this completed application for your records.

SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- · If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older
- In "Relationship" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 8).
- If any dependents are under age 19 and do NOT reside with the proposed insured, the custodial parent must also sign the application (see *Signature Section* on Page 8).

SECTION 2 - PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

SECTION 4 – U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or green card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- · Applicants must reside in the U.S. at least one year prior to being eligible to apply for coverage.
- · Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

SECTION 15 – TYPE OF COVERAGE

• If applicant is applying for coverage other than "Individual," please indicate if still interested in coverage if one or more applicants is declined or ineligible. If "Yes" is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If "No" is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.





IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seg., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seg. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

This authorization must be signed by each app	licant age 18 or older.	
Print Name(s)	Signature	Date
List applicants under age 18 (Print Name).		
-		
	Deposition of Occasions	/
		Date
	Print Name(s)	



Application for Health Insurance

1 WHO IS APPL	YIN	IG								
Read all instructions	for S	Section 1 before cor	npleting	g.						
First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Sec	curity No.	Heigh	t Weight
				Self					fti	n. Ibs
										nlbs
									fti	nlbs
									fti	nlbs
									fti	nlbs
									fti	nlbs
_									fti	n. Libs
2 PARENT/GUA Additional information							ting.			
First N	lame	,	M.I.	Last	Name		Rel	ationship (CI	neck On	e)
							☐ Mother ☐ Father	☐ Stepmo	ther [☐ Guardian
3 MARITAL STA	TU	S								
☐ Single (including v	vido	wed or divorced)		☐ Married (includ	ing separated	1)			
4 U.S. CITIZENS Additional informatio ☐ Yes ☐ No Are a	n ma all ap	ay be required. Rea	s? If "no	," please provid	e the r	ame(s) of the	applicant(s) wh	no are not U	.S. citize	ens.
						Name:				
5 RESIDENTIAL Street	- Al	JUKESS (Must	pe pe	rmanent ad	ares	s - No P.O. City		State	Zip)
ou oot						Oity		AR	<u></u> ,	,
6 MAILING ADD	RE	SS (Complete	onlv i	f different fr	om r	esidential	address)			
Street or P.O. Box						City	•	State	Zip	
7 BILLING MOD	E									
List Bill #:										
8 CONTACT IN	FOF	RMATION		_						
Primary Phone Num	ber	Alternate Phone N	lumber	Best Time to AM PM	Call	E-mail	Address	comm		refer we with you? □ Phone
9 HOUSEHOLD	INF	ORMATION								
☐ Yes ☐ No a. Do		applicants reside ir				•				
		on:								
☐ Yes ☐ No b. De			n Arkan	sas? If "no," p	rovide	reason and h	nis/her name a	and address	s:	
		· · · · · · · · · · · · · · · · · · · 								
R	easc	on:								
OFFICE USE ON	ILY	(Do Not Write I	n This	s Space)						
I.D. No.			Group I	No.			Effective Da	ate		

10 AF	PLICA	ANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]	
Name:		Employer:	
Job Du	ties:		
Name:		Employer:	
Job Du	ties:		
11 CI	JRREN	NT/PREVIOUS INSURANCE INFORMATION	
□ Yes	□ No	 a. Will the coverage applied for replace or change current hospital, medical or major medical coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the appliciant. If "yes," please provide name of carrier: ii. If "yes," does the coverage have a specified termination date? If so, please provide in the coverage have a specified termination date? 	eant?
□ Yes	□ No		
		b. Have you recently lost employer-sponsored health coverage? If "yes," please provide:	://
☐ Yes	□ No	Name:Carrier Name: Termination Date c. Have you recently "involuntarily" lost other health coverage? If "yes," please provide: Name:Carrier Name: Termination Date	· / /
□ Yes	□ No	d. Will any applicants be continuing any other health insurance? If yes, please provide: Name:	
□ Yes	□ No	Name: Carrier Name: ID# e. Are any applicants covered by Medicaid (other than Women's Health/Family Planning covered please provide name(s) below: Name: Name: ID#	
□ Yes	□ No	Name: f. Are any applicants covered by Medicare? If "yes," please provide name(s) below: Name: Name:	- - -
12 DI	RIVER	'S LICENSE INFORMATION [applicant(s) age 14 and older]	
Name:		License No. : State:_	
		License No.: State:_	
		License No.: State:_	
In the p	ast 5 ye	ars, has any applicant:	
		a. Had his or her driver's license suspended or revoked?b. Had two or more moving traffic violations?	
		 c. Been convicted or charged with driving under the influence of alcohol or a controlled substall f you answered "yes," to any of the above questions, you MUST provide the following infor 	
Name:		Date:/ Violation(s):	
Name:		Date:/ Violation(s):	
13 SI	PORTI	NG OR HOBBY INFORMATION	
		Does any applicant intend to pilot a private aircraft; race a motor vehicle, boat or snowmobile; participate in sky or scuba diving, ballooning, mountain climbing, hang gliding or any other	or
Namai		hazardous sport, hobby or activity?	
name.		Please explain:	
		Please explain: Please explain:	
Name:			
Name:	RAVEL	Please explain:	
Name: 14 Ti	RAVEL □ No	Please explain: OUTSIDE THE USA Is any applicant planning to travel or work outside the USA within the next two years? If "yes," please provide the following: nat apply):	
Name: 14 Ti	RAVEL No ilist all the	Please explain: OUTSIDE THE USA Is any applicant planning to travel or work outside the USA within the next two years? If "yes," please provide the following:	

15 TYPE OF COVERAGE	
☐ Individual ☐ Individual and Spouse ☐ Individual	dual and Child(ren)
Yes No If you are applying for coverage other than more applicants is declined or ineligible?	"Individual," are you interested in coverage if one or
16 BENEFITS SELECTION	
MUST CHOOSE	ONE BOX ONLY
Comprehensive Blue PPO III	HSA Blue PPO II
□ \$ 1,000 deductible□ \$ 1,500 deductible	\$ 1,500 individual/ \$ 3,000 family deductible
□ \$ 2,500 deductible□ \$ 5,000 deductible	A A B A B A B B B B B B B B B B
□ \$ 7,500 deductible	\$ 2,500 individual/ \$ 5,000 family deductible
□ \$10,000 deductible□ \$15,000 deductible	☐ \$ 5,000 individual/
☐ \$20,000 deductible	\$10,000 family deductible
□ \$25,000 deductible	
17 OPTIONAL BENEFITS SELECTION	
OPTIONAL MATERNITY BENEFITS	
OF HORAL MATERIAL DENELLING	
Yes, I want to apply for the maternity benefits.	
	overage has been in effect for 12 months. There is no per ilable to females age 19 or older. Dependents other than a r.

17 OPTIONAL BENEFITS SELECTION (continued) **OPTIONAL TERM LIFE** Underwritten by USAble Life and billed with your health insurance. USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life policy referenced here. Term Life is available only on the proposed insured and spouse. (Proposed insured must be 19 - 64 years of age.) Choose only one of the following: ☐ Proposed Insured ☐ Proposed Insured and Spouse (Spouse must also be applying for health insurance coverage on this application.) Choose one of the following coverage amounts: □ \$10,000 □ \$30,000 □ \$50.000 If both the proposed insured and spouse choose Term Life, the coverage amounts will be the same. • Benefits will be paid to the designated beneficiary(ies) in one lump sum. Premiums are based on the age of the oldest person applying for coverage and increase when that person's age moves to the next age bracket. Your monthly premiums will be billed with your Arkansas Blue Cross and Blue Shield health insurance coverage. · Your Term Life coverage will become effective at the same time as your Arkansas Blue Cross and Blue Shield health insurance coverage. **Beneficiary Designation for Optional Term Life Insurance Benefits** I hereby designate the following beneficiary(ies) for the USAble Life Term Life insurance and revoke the appointment of any existing beneficiary, if making a change in beneficiary(ies). If I designate more than one beneficiary, those who survive will share equally unless specified otherwise. The beneficiary for the Term Life insurance on a covered spouse will be the proposed insured. **PRIMARY BENEFICIARY(IES)** (Will receive proceeds if living at death of proposed insured.) Percentage Date Address Relationship Name (First, MI, Last) Social Security No. of Birth Distribution Total must equal 100% = CONTINGENT BENEFICIARY(IES) (Will receive proceeds if all primary beneficiary(ies) are not living.) Date Percentage Relationship Name (First, MI, Last) Address Social Security No. Distribution of Birth

Total must equal 100% =

18 EX	(PECTA	NT/AD	OPTIVE	PARENT INFORMA	TION						
☐ Yes	□ No Is	any ma	le applying	g for coverage an expectar	nt father or a p	otentia	l adopti	ve fath	er?		
☐ Yes	□ No Is	any fen	nale applyi	ing for coverage pregnant	or a potential	adoptiv	e mothe	er?			
If "yes,"	please pro	vide the	following:	Name:		Expect	ed Deliv	/ery/A	doption Date: _	/	/
19 IN	FERTIL	.ITY									
Has any	applicant	t or spou	ise of a pr	oposed applicant (wheth	er applying	for co	verage	or not):		
			_	osed or treated for inferti rilization? If "yes" to ques	•	please	provide	the fo	ollowing:		
	Name:			Treatment/	Procedure:				Date:	/	/
				Treatment/							
20 TC	0 TOBACCO USAGE										
☐ Yes			applicant t ne followin	o be covered used any fo	orm of tobacc	o withi	n the la	st 12 n	nonths? If "yes,"	" please	!
	Name:_			Type/Amou	nt:			_ Date	Last Used:	/	/
	Name: _			Type/Amou	nt:			_ Date	Last Used:	/	/
	Name: _			Type/Amou	nt:			_ Date	Last Used:	/	/
21 PF				EXPERIENCE							
☐ Yes	□ No H	las any a r long-te	applicant e rm care in	ever been declined, rated surance? If "yes," please	, restricted or provide the	modifi followir	ied for t	he issı	uance of life, ac	cident, I	nealth
	Name: _			Carrier Name:		Ye	ear:	De	etails:		
				Carrier Name:							
22 PF	RESCRII	PTION	QUEST	IONNAIRE							
If you a	p nswered ' ne same i	rescription "yes," plain nformation se prov	on medicate ease provious tion required the n	plicant currently taking a ation in the last 3 years? vide full details below. U ested here and must be ame that would have be	se separate e signed an	sheet i	f neces	sary. <i>I</i> int out	Any attachme	nt must	not
Person	Na		Dosage	Specific Disorder	Start Date/		e of Rec			te Name	
Treated	of D	rug	333	or Illness	Stop Date	None	Partial	Full	Address of Pre	escribing	Physician
					mo year						
					mo year						
					mo year						
					mo year						
					mo year						
					mo year						
					mo year / mo year						
					mo year						
					mo year						

23 MEDICAL QUESTIONNAIRE

□ Pyloric stenosis

☐ Any other disorder of stomach, intestines,

■ None of the above apply to any applicant(s)

liver, gallbladder or rectum

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

Has any applicant ever had or been told he/she had: (Each section must have at least one box checked. When multiple

'	medical conditions are listed, please circ	cle all conditions that apply.)	St one box enecked. When manple
	BRAIN OR NERVOUS SYSTEM DISORDERS Alzheimer's disease or senile dementia Amyotrophic lateral sclerosis (Lou Gehrig's disease) Cerebral palsy Concussion or brain injury Convulsions, epilepsy or seizures Headaches or migraines Meningitis Multiple sclerosis, muscular dystrophy or myasthenia gravis Neuritis Paralysis or palsy Parkinson's disease Polyneuritis	D. KIDNEY, URINARY, REPRODUCTIVE Abnormal pap smear Bladder or renal stones Cesarean section or miscarriage Dialysis Nephritis Nephrotic syndrome, renal disease or failure Sexually transmitted disease Sugar, blood or protein in urine Any other disorder of the kidneys or urinary tract Any other disorder of the male reproductive organs, including prostate Any other disorder of the female reproductive organs, including ovaries or breasts None of the above apply to any applicant(s)	MUSCULOSKELETAL (cont.) □ Fracture(s) or broken bone(s) Exposed bone □ Yes □ No □ Gout □ Lupus, systemic □ Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder □ Any other disorder of the muscles, bones or joints to include chiropractic care □ None of the above apply to any applicant(s) I. EARS/EYES/NOSE/THROAT □ Cataracts or glaucoma □ Meniere's disease □ Nasal septal defect □ Sinusitis toosillitis or offits media
	system	E. RESPIRATORY ☐ Allergies, asthma or bronchitis	 ☐ Sinusitis, tonsillitis or otitis media ☐ Any other disorder of the eyes, ears, nose, throat or esophagus ☐ None of the above apply to any applicant(s)
B .	Angina, heart attack, myocardial infarction Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty	 □ Chronic pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV) □ Obstructive or reactive airway disorder □ Sleep apnea, cpap, bipap or vpap □ Any other disorder of the lungs, bronchial tubes or respiratory system □ None of the above apply to any applicant(s) 	J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE □ Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder □ Attempted suicide □ Counseling or psychiatric treatment (in-patient
	palpitation of the heart, ablation, rheumatic fever Heart bypass surgery, pacemaker implant Heart or vein/artery surgery High blood pressure	F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS Anemia Cancer, leukemia or malignancy of any kind Hodgkin's or Non-Hodgkin's disease Melanoma, neoplasm or tumor Any other disorder of the lymphatic system	or out-patient) Bipolar disorder, obsessive compulsive disorder or developmental disorder Eating disorder Any other mental, emotional disorder or situation, including ADD/ADHD None of the above apply to any applicant(s) K. OTHER
	Any other disorder of the heart, blood, blood vessels or circulatory system	☐ Any other disorder of the skin☐ None of the above apply to any applicant(s)☐ G. GLANDULAR DISORDERS	□ Current patient in a hospital or nursing home □ Pending Surgery Surgery Date:/_/_ □ Sarcoidosis
c	Crohn's disease or ulcerative colitis Gastric bypass surgery or other weight loss procedure	 □ Adrenal disorders □ Diabetes, abnormal glucose □ Goiter or thyroid disease □ Any disorder of the pancreas □ None of the above apply to any applicant(s) 	□ Breast implants □ Saline □ Silicone Surgery Date:/_/ □ Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents) □ Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune
	Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)	H. MUSCULOSKELETAL ☐ Arthritis, osteoarthritis, degenerative joint or disc disease ☐ Back pain and/or neck pain ☐ Chronic fatigue ☐ Connective tissue disorder	deficiency disorder or HIV ☐ Transplant recipient ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere ☐ None of the above apply to any applicant(s)

 \square Disease or disorder of the joints: knee(s),

shoulder(s), elbow(s), wrist(s), other

☐ Fibromyalgia, bursitis or tendonitis

23 MEI	DICAL QUES	STIONNAIRE (coi	ntinued)							
2. Has a	ny applicant ever	r:								
☐ Yes	s □ No a. Co	onsumed alcohol to exc	ess, received tre	eatment, or jo	ined an org	ganizatio	n for ald	coholis	m or drug	g addictions?
☐ Yes		sed any addictive or noi								-
☐ Yes										
	or had any indication(s) of having a drug dependency/habit?									
☐ Yes										
	ple	ease explain:								
☐ Yes	s □ No e. Be	een told that he/she has	or has had hea	ring problems	s, ear disor	der(s) or	has ne	ed of h	earing d	evices due
	to	any kind of hearing or e	ear impairment, o	or does any a	applicant ha	ave an ex	xisting h	nearing	aid devi	ce in place?
		ADDIT	CIONIAL ME	DICAL IN	IEODM	ATION				
			TIONAL ME							
Give full	details to quest	ions answered affirma	atively (checked	d or answere	ed "Yes") t	o explai	n answ	ers to	questio	ns in
SECTION	N 23. In additior	n to condition/illness	please provide	e the type o	f treatme	nt provi	ded or p	planne	ed – for o	example,
	•	b tests, hospitalization			-					
services,	occupational th	nerapy, physical thera	py, speech thei	rapy or chird	practic tre	atments	s. Pleas	se ens	ure you	include all
the treatr	ments that apply	y. Please use the nar	me that would	have been	given at t	he time	of the	phys	ician vi	sit — e.g., a
maiden ı	name.									
Question	Person	Specific Disorder/Illne	ess Date of	Date of	Total #	Degree	of Rec	overv	Cor	mplete Name
Number(s)	Treated	and Type of Treatme		Last Visit	of Visits	1 - 3			dress of Physician	
		,,				110110	- Gradi			
			,	,						
			mo 'year	mo 'year	-					
				,						
			,	,						
			mo 'year	mo 'year	_					
			,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
			/	/						
			mo year	mo year						
			/	//						
			mo year	mo year						
			,	,						
			mo year	mo 'year	-					
24 DII	VOICLAN INT					4l	l = = 4 £ :-			
		FORMATION (Plea								Tro otro ont/
App	olicant's Name	Complete	Name and Addre	ess of Physici	an	Date Last Vi		Reas for Vi	SON sit**	Treatment/ Results**
						Lust VI	OIL	101 11	Oit	results
*Please writ	te NO VISIT in this	box if the applicant has ne	ever seen the physi	ician. **Us	se "Commen	ts" section	n on Pag	e 9 if m	ore room	is needed for details.

PLEASE READ BEFORE SIGNING

By completing this list bill application, which authorizes my employer to remit my premium to Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), I understand and agree: (1) My employer will payroll deduct my premium from my compensation and remit the premium amount to COMPANY. (2) My employer is not acting as an agent of COMPANY but is, instead, at all times acting as my representative. (3) I am responsible for the payment of the premium. Therefore, if my employer fails to submit the required amounts when due, all coverage will terminate as of the due date. (4) If my employer fails to submit the required amounts when due, COMPANY has no obligation to seek payment directly from me. (5) I will not hold COMPANY liable for loss of coverage or benefits due to failure by my employer to remit payment in a timely manner. (6) My coverage is not dependent upon this billing arrangement; therefore, I may change to having COMPANY bill me directly with 15 days advance written notice to my employer and COMPANY. (7) I understand that termination of my employment shall terminate payroll deduction and employer remittance of premium to COMPANY. (8) I understand that my employer or COMPANY may terminate this arrangement by giving me written notice, but this will not terminate my insurance coverage. (9) If this payroll deduction and premium remittance is terminated, in order for me to keep my insurance coverage in force, I must make premium payments directly to COMPANY.

I UNDERSTAND: (1) This application will be medically underwritten in order to assess the potential financial risk of each individual on the application. As the result of the assessment, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, I may have particular conditions or body parts excluded, or I may be declined for coverage. If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/ or offered coverage with non-medical exclusions. (2) If I am age 19 or older, I will not have any benefits provided for 12 months for the treatment of any condition which existed before the effective date of my coverage. (3) The agent or broker involved in this insurance transaction may receive compensation from the COMPANY or one of its affiliates, for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (4) Any coverage which may be issued to me shall be invalid if based on intentional misrepresentation of material fact provided by me on the application. (5) The COMPANY may phone me for additional information that may help with the timely processing of my application. (6) The Health insurance and Term Life insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) understand that the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request.

I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE SECTION (Ple	ase sign appropriate line only)	
Proposed Insured OR		Date Signed
Parent/Legal Guardian's (if policy for a minor)	x	
Spouse		Date Signed
(required if applying)	X	
Dependent age 18 or older (required if applying)		Date Signed
(required if applying)	X	
Dependent age 18 or older		Date Signed
(required if applying)	X	
CUSTODIAL PARENT SECT		
	age 19, named on this application do NOT reside with the propo the custodial parent's signature is required.	
Custodial Parent's Name and Address		Telephone No.
(please print)	X	
Custodial Parent's		Date Signed
Signature	X	

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

POLICY EFFECTIVE DATE

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 1st of the **month after next** if the application is approved on the 11th through the end of the **current month**.

Approval Date
1st - 10th
11th - last day of the month

Estamples

1st of the following month
1st of the month after next

Approved Jan. 2; effective Feb. 1
Approved Jan. 27; effective Mar. 1



Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 2181, Little Rock, AR 72203-2181 www.ArkansasBlueCross.com



FARM BUREAU ARKANSAS

List Bill Individual/Family Health Insurance Application

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This application is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information
 provided must be accurate and legible.
- This application must be completed in dark blue or black ink. Applications completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this application.
- Any **attachments** submitted with the application must be signed and dated.
- Do not send any money with this application.
- Please ensure all required parties have signed and dated the application prior to submission.
- · We strongly recommend you make a copy of this completed application for your records.

SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older
- In "Relationship" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 8).
- If any dependents are under age 19 and do NOT reside with the proposed insured, the custodial parent must also sign the application (see *Signature Section* on Page 8).

SECTION 2 - PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

SECTION 4 – U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or green card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- · Applicants must reside in the U.S. at least one year prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

SECTION 15 – TYPE OF COVERAGE

• If applicant is applying for coverage other than "Individual," please indicate if still interested in coverage if one or more applicants is declined or ineligible. If "Yes" is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If "No" is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.





IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seg., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seg. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

This authorization must be signed by each app	licant age 18 or older.	
Print Name(s)	Signature	Date
List applicants under age 18 (Print Name).		
-		
	Deposition of Occasions	/
		Date
	Print Name(s)	



Application for Health Insurance



1 WHO IS APPL	YIN	IG								
Read all instructions	for S	Section 1 before cor	npleting	g.						
First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Sec	curity No.	Heigh	t Weight
				Self					fti	n. Ibs
										nlbs
									fti	nlbs
									fti	nlbs
									fti	nlbs
									fti	nlbs
_									fti	n. Libs
2 PARENT/GUA Additional information							ting.			
First N	lame	,	M.I.	Last	Name		Rel	ationship (CI	neck On	e)
							☐ Mother ☐ Father	☐ Stepmo	ther [☐ Guardian
3 MARITAL STA	TU	S								
☐ Single (including v	vido	wed or divorced)		☐ Married (includ	ing separated	1)			
4 U.S. CITIZENS Additional informatio ☐ Yes ☐ No Are a	n ma all ap	ay be required. Rea	s? If "no	," please provid	e the r	ame(s) of the	applicant(s) wh	no are not U	.S. citize	ens.
						Name:				
5 RESIDENTIAL Street	- Al	JUKESS (Must	pe pe	rmanent ad	ares	s - No P.O. City		State	Zip)
ou oot						Oity		AR	<u></u> ,	,
6 MAILING ADD	RE	SS (Complete	onlv i	f different fr	om r	esidential	address)			
Street or P.O. Box						City	•	State	Zip	
7 BILLING MOD	E									
List Bill #:										
8 CONTACT IN	FOF	RMATION		_						
Primary Phone Num	ber	Alternate Phone N	lumber	Best Time to AM PM	Call	E-mail	Address	comm		refer we with you? □ Phone
9 HOUSEHOLD	INF	ORMATION								
☐ Yes ☐ No a. Do		applicants reside ir				•				
		on:								
☐ Yes ☐ No b. De			n Arkan	sas? If "no," p	rovide	reason and h	nis/her name a	and address	s:	
		· · · · · · · · · · · · · · · · · · · 								
R	easc	on:								
OFFICE USE ON	ILY	(Do Not Write I	n This	s Space)						
I.D. No.			Group I	No.			Effective Da	ate		

10 AF	PLICA	ANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]	
Name:		Employer:	
Job Du	ties:		
Name:		Employer:	
Job Du	ties:		
11 CI	JRREN	NT/PREVIOUS INSURANCE INFORMATION	
□ Yes	□ No	 a. Will the coverage applied for replace or change current hospital, medical or major medical coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the appliciant. If "yes," please provide name of carrier: ii. If "yes," does the coverage have a specified termination date? If so, please provide in the coverage have a specified termination date? 	eant?
□ Yes	□ No		
		b. Have you recently lost employer-sponsored health coverage? If "yes," please provide:	://
☐ Yes	□ No	Name:Carrier Name: Termination Date c. Have you recently "involuntarily" lost other health coverage? If "yes," please provide: Name:Carrier Name: Termination Date	· / /
□ Yes	□ No	d. Will any applicants be continuing any other health insurance? If yes, please provide: Name:	
□ Yes	□ No	Name: Carrier Name: ID# e. Are any applicants covered by Medicaid (other than Women's Health/Family Planning covered please provide name(s) below: Name: Name: ID#	
□ Yes	□ No	Name: f. Are any applicants covered by Medicare? If "yes," please provide name(s) below: Name: Name:	- - -
12 DI	RIVER	'S LICENSE INFORMATION [applicant(s) age 14 and older]	
Name:		License No. : State:_	
		License No.: State:_	
		License No.: State:_	
In the p	ast 5 ye	ars, has any applicant:	
		a. Had his or her driver's license suspended or revoked?b. Had two or more moving traffic violations?	
		 c. Been convicted or charged with driving under the influence of alcohol or a controlled substall f you answered "yes," to any of the above questions, you MUST provide the following infor 	
Name:		Date:/ Violation(s):	
Name:		Date:/ Violation(s):	
13 SI	PORTI	NG OR HOBBY INFORMATION	
		Does any applicant intend to pilot a private aircraft; race a motor vehicle, boat or snowmobile; participate in sky or scuba diving, ballooning, mountain climbing, hang gliding or any other	or
Namai		hazardous sport, hobby or activity?	
name.		Please explain:	
		Please explain: Please explain:	
Name:			
Name:	RAVEL	Please explain:	
Name: 14 Ti	RAVEL □ No	Please explain: OUTSIDE THE USA Is any applicant planning to travel or work outside the USA within the next two years? If "yes," please provide the following: nat apply):	
Name: 14 Ti	RAVEL No ilist all the	Please explain: OUTSIDE THE USA Is any applicant planning to travel or work outside the USA within the next two years? If "yes," please provide the following:	

15 TYPE OF COVERAGE	
☐ Individual ☐ Individual and Spouse ☐ Individual	dual and Child(ren)
Yes No If you are applying for coverage other than more applicants is declined or ineligible?	"Individual," are you interested in coverage if one or
16 BENEFITS SELECTION	
MUST CHOOSE	ONE BOX ONLY
Comprehensive Blue PPO III	HSA Blue PPO II
 □ \$ 1,000 deductible □ \$ 1,500 deductible □ \$ 2,500 deductible 	\$ 1,500 individual/ \$ 3,000 family deductible
□ \$ 5,000 deductible □ \$ 7,500 deductible	\$ 2,500 individual/ \$ 5,000 family deductible
 □ \$10,000 deductible □ \$15,000 deductible □ \$20,000 deductible 	\$ 5,000 individual/ \$10,000 family deductible
□ \$25,000 deductible	
17 OPTIONAL BENEFITS SELECTION	
OPTIONAL MATERNITY BENEFITS	
	overage has been in effect for 12 months. There is no per
pregnancy dollar maximum. This benefit is only avail	lable to females age 19 or older. Dependents other than a

18 EX	(PECTAI	NT/AD	OPTIVE	PARENT INFORMA	TION						
☐ Yes	□ No Is	any ma	le applying	g for coverage an expectar	nt father or a p	otentia	ıl adopti	ve fath	er?		
☐ Yes	es										
If "yes,"	f "yes," please provide the following: Name:Expected Delivery/Adoption Date://										
19 IN	19 INFERTILITY										
Has any	Has any applicant or spouse of a proposed applicant (whether applying for coverage or not):										
	I Yes □ No a. Ever been diagnosed or treated for infertility? I Yes □ No b. Had surgical sterilization? If "yes" to question a. or b., please provide the following:										
	Name: Date: Treatment/Procedure: Date:/										
	Name: Treatment/Procedure: Date://										
20 TC	20 TOBACCO USAGE										
☐ Yes			applicant t ne followin	o be covered used any fog:	orm of tobacc	o withi	n the la	st 12 n	nonths? If "yes,"	' please	
	Name: _			Type/Amou	nt:			_ Date	Last Used:	/	/
	Name: _			Type/Amou	nt:			_ Date	Last Used:	/	/
	Name: _			Type/Amou	nt:			_ Date	Last Used:	/	/
21 PF				EXPERIENCE							
☐ Yes	□ No Ha	as any a long-te	applicant e rm care in	ever been declined, rated surance? If "yes," please	, restricted or provide the	modifi followir	ied for t	he issı	uance of life, ac	cident, h	nealth
	Name: _			Carrier Name:		Ye	ear:	De	etails:		
				Carrier Name:							
22 PF	RESCRIF	PTION	QUEST	IONNAIRE							
If you a	pr nswered " ne same in	escription yes," plants of the province of the	on medicate ease provious tion required in the the new medium in the med	plicant currently taking a ation in the last 3 years? vide full details below. U ested here and must be ame that would have be	se separate e signed an	sheet i	if neces	sary. <i>I</i> int out	Any attachment from the pharm	nt must	not
Person	Nar		Dosage	Specific Disorder	Start Date/		e of Rec			te Name	
Treated	of Di	rug		or Illness	Stop Date	None	Partial	Full	Address of Pre	scribing	Physician
					mo year						
					mo year						
					mo year						
					mo year						
					mo year						
					mo year						
					mo year / mo year						
					mo year						
					mo year						

23 MEDICAL QUESTIONNAIRE

□ Pyloric stenosis

☐ Any other disorder of stomach, intestines,

■ None of the above apply to any applicant(s)

liver, gallbladder or rectum

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

1,	medical conditions are listed, please cir	cle all conditions that apply.)	ist one box checked. When multiple
	Amyotrophic lateral sclerosis (Lou Gehrig's disease) Cerebral palsy Concussion or brain injury Convulsions, epilepsy or seizures Headaches or migraines Meningitis	D. KIDNEY, URINARY, REPRODUCTIVE □ Abnormal pap smear □ Bladder or renal stones □ Cesarean section or miscarriage □ Dialysis □ Nephritis □ Nephrotic syndrome, renal disease or failure □ Sexually transmitted disease □ Sugar, blood or protein in urine □ Any other disorder of the kidneys or urinary tract	MUSCULOSKELETAL (cont.) □ Fracture(s) or broken bone(s) Exposed bone □ Yes □ No □ Gout □ Lupus, systemic □ Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder □ Any other disorder of the muscles, bones or joints to include chiropractic care □ None of the above apply to any applicant(s)
	Neuritis Paralysis or palsy Parkinson's disease Polyneuritis Vertigo, fainting or dizziness	 □ Any other disorder of the male reproductive organs, including prostate □ Any other disorder of the female reproductive organs, including ovaries or breasts □ None of the above apply to any applicant(s) E. RESPIRATORY 	I. EARS/EYES/NOSE/THROAT ☐ Cataracts or glaucoma ☐ Meniere's disease ☐ Nasal septal defect ☐ Sinusitis, tonsillitis or otitis media ☐ Any other disorder of the eyes, ears, nose, throat or esophagus
	CIRCULATORY Abnormal cholesterol/lipids Angina, heart attack, myocardial infarction Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty Cerebrovascular accident (stroke), including	 □ Allergies, asthma or bronchitis □ Chronic pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV) □ Obstructive or reactive airway disorder □ Sleep apnea, cpap, bipap or vpap □ Any other disorder of the lungs, bronchial tubes or respiratory system □ None of the above apply to any applicant(s) 	 □ None of the above apply to any applicant(s) J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE □ Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder □ Attempted suicide □ Counseling or psychiatric treatment (in-patient or out-patient)
	Heart or vein/artery surgery High blood pressure Hemophilia Valve repair/replacement Any other disorder of the heart, blood, blood vessels or circulatory system	F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS ☐ Anemia ☐ Cancer, leukemia or malignancy of any kind ☐ Hodgkin's or Non-Hodgkin's disease ☐ Melanoma, neoplasm or tumor ☐ Any other disorder of the lymphatic system ☐ Any other disorder of the skin ☐ None of the above apply to any applicant(s) G. GLANDULAR DISORDERS	□ Bipolar disorder, obsessive compulsive disorder or developmental disorder □ Eating disorder □ Any other mental, emotional disorder or situation, including ADD/ADHD □ None of the above apply to any applicant(s) K. OTHER □ Current patient in a hospital or nursing home □ Pending Surgery Surgery Date:/_/ □ Sarcoidosis
C.	Crohn's disease or ulcerative colitis Gastric bypass surgery or other weight loss procedure	□ Adrenal disorders □ Diabetes, abnormal glucose □ Goiter or thyroid disease □ Any disorder of the pancreas □ None of the above apply to any applicant(s)	□ Breast implants □ Saline □ Silicone Surgery Date:/_/ □ Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents) □ Acquired immune deficiency syndrome
	Hepatitis Hernia, hemorrhoids	 H. MUSCULOSKELETAL □ Arthritis, osteoarthritis, degenerative joint or disc disease □ Back pain and/or neck pain □ Chronic fatigue □ Connective tissue disorder 	 (AIDS), or AIDS-related complex or immune deficiency disorder or HIV □ Transplant recipient □ Any injury, deformity, incapacitation, disease or condition not listed elsewhere □ None of the above apply to any applicant(s)

Form No. U-65 List Bill FB (R01/12) Page 5 (Continued on page 6)

 \square Disease or disorder of the joints: knee(s),

shoulder(s), elbow(s), wrist(s), other

☐ Fibromyalgia, bursitis or tendonitis

23 MEI	DICAL QUES	STIONNAIRE (co	ntinued)									
2. Has a	ny applicant ever	r:										
☐ Yes	s □ No a. Co	onsumed alcohol to exc	cess, received tre	eatment, or jo	ined an org	ganizatio	n for ald	coholis	m or drug	g addictions?		
☐ Yes	☐ Yes ☐ No b. Used any addictive or non-addictive drug or substance for purposes other than recommended by your physician?											
☐ Yes	☐ Yes ☐ No c. Been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider,											
	or had any indication(s) of having a drug dependency/habit?											
☐ Yes	☐ Yes ☐ No d. Required the assistance of any other individual for performances of any activities of daily living? If "Yes,"											
	please explain:											
☐ Yes	☐ Yes ☐ No e. Been told that he/she has or has had hearing problems, ear disorder(s) or has need of hearing devices due											
	to any kind of hearing or ear impairment, or does any applicant have an existing hearing aid device in place?											
	ADDITIONAL MEDICAL INFORMATION											
Give full	Give full details to questions answered affirmatively (checked or answered "Yes") to explain answers to questions in											
SECTION	SECTION 23. In addition to condition/illness please provide the type of treatment provided or planned – for example,											
	surgery, X-rays, EKG, lab tests, hospitalization, emergency room visit, nursing home confinement, doctor visits, rehabilitation											
services,	occupational th	nerapy, physical thera	ipy, speech thei	apy or chird	practic tre	atments	s. Pleas	se ens	ure you	include all		
the treatr	ments that apply	y. Please use the na	me that would	have been	given at t	he time	of the	phys	ician vi	sit — e.g., a		
maiden ı	the treatments that apply. Please use the name that would have been given at the time of the physician visit — e.g., a maiden name.											
Question	Person	Specific Disorder/Illne	ess Date of	Date of	Total #	Degree	of Rec	overv	Cor	mplete Name		
Number(s)	Treated	and Type of Treatme		Last Visit	of Visits	_	Partial			dress of Physician		
		7.				110110	- Gradi					
				,								
			mo 'year	mo 'year	-							
			,	,								
				,								
			mo year	mo 'year	_							
			,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
			,	/								
			mo year	mo year								
			/	/								
			mo year	mo year								
			,	,								
			mo 'year	mo 'year	-							
24 DU	VOICLAN INT					4l	l = = 4 £ :-					
		FORMATION (Plea								Tro otro ont/		
App	olicant's Name	Complete	Name and Addre	ess of Physici	an	Date (Last Vi		Reas for Vi	SON sit**	Treatment/ Results**		
						Lust VI	OIL	101 11	Oit	results		
*Please writ	Please write NO VISIT in this box if the applicant has never seen the physician. **Use "Comments" section on Page 9 if more room is needed for details.											

Applicant must read and initial all sections

Initials	12-Month Pre-Existing Conditions Exclusion Period I understand that all persons, age 19 or older, approved for coverage will have a 12-month pre- existing exclusions waiting period. A pre-existing condition or disease is one that causes symptoms, before the effective date of the policy, that would have caused an ordinarily prudent person to seek diagnosis, care or treatment. This also applies to aggravations of such conditions or diseases.
Initials	Fraud or Misrepresentation I understand that if I knowingly present intentional misrepresentations of material fact provided by me on this application, my policy may be reformed or rescinded.
Initials	Maternity Rider Maternity benefits are payable once the maternity coverage has been in effect for 12 months. There is no per pregnancy dollar maximum. This benefit is only available to females age 19 or older. Dependents other than a covered spouse cannot purchase the maternity rider.
Agent Initials	I have thoroughly reviewed all of the information above with the applicant(s).

PLEASE READ BEFORE SIGNING

By completing this list bill application, which authorizes my employer to remit my premium to Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), I understand and agree: (1) My employer will payroll deduct my premium from my compensation and remit the premium amount to COMPANY. (2) My employer is not acting as an agent of COMPANY but is, instead, at all times acting as my representative. (3) I am responsible for the payment of the premium. Therefore, if my employer fails to submit the required amounts when due, all coverage will terminate as of the due date. (4) If my employer fails to submit the required amounts when due, COMPANY has no obligation to seek payment directly from me. (5) I will not hold COMPANY liable for loss of coverage or benefits due to failure by my employer to remit payment in a timely manner. (6) My coverage is not dependent upon this billing arrangement; therefore, I may change to having COMPANY bill me directly with 15 days advance written notice to my employer and COMPANY. (7) I understand that termination of my employment shall terminate payroll deduction and employer remittance of premium to COMPANY. (8) I understand that my employer or COMPANY may terminate this arrangement by giving me written notice, but this will not terminate my insurance coverage. (9) If this payroll deduction and premium remittance is terminated, in order for me to keep my insurance coverage in force, I must make premium payments directly to COMPANY.

I UNDERSTAND: (1) This application will be medically underwritten in order to assess the potential financial risk of each individual on the application. As the result of the assessment, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, I may have particular conditions or body parts excluded, or I may be declined for coverage. If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/ or offered coverage with non-medical exclusions. (2) If I am age 19 or older, I will not have any benefits provided for 12 months for the treatment of any condition which existed before the effective date of my coverage. (3) The agent or broker involved in this insurance transaction may receive compensation from the COMPANY or one of its affiliates, for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (4) Any coverage which may be issued to me shall be invalid if based on intentional misrepresentation of material fact provided by me on the application. (5) The COMPANY may phone me for additional information that may help with the timely processing of my application. (6) The Health insurance and Term Life insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) understand that the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request.

I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE SECTION (Ple	ase sign appropriate line only)	
Proposed Insured OR		Date Signed
Parent/Legal Guardian's (if policy for a minor)	x	
Spouse (required if applying)	x	Date Signed
Dependent age 18 or older (required if applying)		Date Signed
Donandant ago 19 ar aldar	X	Date Signed
Dependent age 18 or older (required if applying)	x	Date eigned
CUSTODIAL PARENT SECT	TION	
If any dependents, under	age 19, named on this application do NOT reside with the propo the custodial parent's signature is required.	sed insured,
Custodial Parent's Name and Address (please print)	x	Telephone No.
Custodial Parent's Signature	x	Date Signed
This section to be complete	•	al modical or major
	wledge, will the coverage applied for replace or change any existing hospit is coverage is approved by Arkansas Blue Cross and Blue Shield and acce	
Sales Rep License No. (required)	Sales Representative's Name (Please Print) X	Telephone No.
Agency Federal Tax ID No. 71-0179203	Sales Representative's Signature X	Date Signed
Comments:		

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

POLICY EFFECTIVE DATE

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 1st of the **month after next** if the application is approved on the 11th through the end of the **current month**.

Approval Date 1st - 10th 11th - last day of the month Effective Date

1st of the following month
1st of the month after next

Examples

Approved Jan. 2; effective Feb. 1

Approved Jan. 27; effective Mar. 1



Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 2181, Little Rock, AR 72203-2181 www.ArkansasBlueCross.com



List Bill Individual/Family Health Insurance Application

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This application is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information
 provided must be accurate and legible.
- This application must be completed in dark blue or black ink. Applications completed in pencil will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this application.
- Any **attachments** submitted with the application must be signed and dated.
- Do not send any money with this application.
- Please ensure all required parties have signed and dated the application prior to submission.
- · We strongly recommend you make a copy of this completed application for your records.

SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- · If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older
- In "Relationship" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 8).
- If any dependents are under age 19 and do NOT reside with the proposed insured, the custodial parent must also sign the application (see *Signature Section* on Page 8).

SECTION 2 - PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

SECTION 4 – U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or green card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- · Applicants must reside in the U.S. at least one year prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

SECTION 15 – TYPE OF COVERAGE

• If applicant is applying for coverage other than "Individual," please indicate if still interested in coverage if one or more applicants is declined or ineligible. If "Yes" is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If "No" is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.





IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seg., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seg. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

This authorization must be signed by each app	licant age 18 or older.	
Print Name(s)	Signature	Date
List applicants under age 18 (Print Name).		
-		
	Deposition of Occasion is	
		Date
	Print Name(s)	



Application for Health Insurance

For Arkansas Blue Cross Use Only									
This application was received by:									
□с	□NW	☐ NE	□ WC						
□sc	□ SW	☐ SE	☐ Customer						
☐ Retail Store Service									
Date Star	mp								

BlueCross Bl	ueSl	nield H	lealt	h Insura	ınc	e [Date Stamp		Servic	
1 WHO IS APP	LYIN	IG								
Read all instructions	s for S	Section 1 before co	mpleting].						
First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Sec	curity No.	Height	Weight
				Self					ftin.	lbs
									ftin.	lbs
									ftin.	lbs
									ftin.	lbs
									ftin.	lbs
									ftin.	lbs
									ftin.	lbs
2 PARENT/GU	ARD	IAN (If policy i	s only	for a child i	unde	er age 19)				
Additional information	on ma	y be required. Rea	ad instru	ctions for Section	on 2 b	efore comple	eting.			
First	Name		M.I.	Last	Name	!	Rel	ationship (C	heck One)	
							☐ Mother ☐ Father	☐ Stepmo		Guardiar
3 MARITAL ST	ATU :	S								
☐ Single (including	wido	wed or divorced)		☐ Married (i	nclud	ing separated	d)			
4 U.S. CITIZEN	SHIF	P STATUS								
Additional informati	on ma	ay be required. Rea	ad instru	ctions for Secti	on 4 l	pefore comple	eting.			
☐ Yes ☐ No Are	all ap	plicants U.S. citizen	s? If "no	," please provide	e the r	name(s) of the	applicant(s) wh	no are not U	J.S. citizens	S.
Na	me:					Name:				
5 RESIDENTIA	LAE	DRESS (Must	be pe	rmanent ad	dres	s - No P.O.	box, pleas	se)		
Street		•				City		State	Zip	
								AR		
6 MAILING AD	DRE	SS (Complete	only if	different fr	om r	esidential	address)			
Street or P.O. Box						City		State	Zip	
7 BILLING MO	DE									
List Bill #:										
8 CONTACT IN	IFOF	RMATION								
Primary Phone Nur	nber	Alternate Phone N	Number	Best Time to	Call	E-mail	Address		lo you pret	
()		()		AM PM					unicate wi -mail	th you? I Phone
9 HOUSEHOLI) INE								-maii L	i i none
☐ Yes ☐ No a. [n the sa	me household	2 If "n	o " provide re	ason and his/	her name a	and addres	· c ·
		:								
		on:								
☐ Yes ☐ No b. [n Arkan	sas? If "no." pr	ovide	reason and I	his/her name a	and addres	s:	
		:		•						
		on:								
OFFICE USE O			In This	s Space)						
I.D. No.			Group I				Effective Da	ite		

10 AP	PLICA	4IV	I(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]						
Name: _			Employer:						
Job Dut	ies:								
Name: _			Employer:						
Job Dut	ies:								
11 CL	JRREN	IT/	PREVIOUS INSURANCE INFORMATION						
□ Yes	□ No	a.	Will the coverage applied for replace or change current hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant? i. If "yes," please provide name of carrier: ii. If "yes," does the coverage have a specified termination date? If so, please provide date:/_/						
□ Yes	□ No		iii. If "yes," and the coverage does not have a specified termination date, will the coverage terminate if approved by Arkansas Blue Cross and accepted by the applicant?						
□ Yes	□ No	b.	Have you recently lost employer-sponsored health coverage? If "yes," please provide: Name: Carrier Name: Termination Date:/_/						
□ Yes	□ No	C.	Have you recently "involuntarily" lost other health coverage? If "yes," please provide:						
□ Yes	□ No	Name:Carrier Name:Termination Date:// \[No d. Will any applicants be continuing any other health insurance? If yes, please provide: Name:ID#							
□ Yes	Name: Carrier Name: ID# es □ No e. Are any applicants covered by Medicaid (other than Women's Health/Family Planning coverage)? If "yes," please provide name(s) below: Name:								
□ Yes	□ No	f.	Name: Are any applicants covered by Medicare? If "yes," please provide name(s) below: Name: Name:						
12 DF	RIVER	'S I	LICENSE INFORMATION [applicant(s) age 14 and older]						
			LICENSE INFORMATION [applicant(s) age 14 and older] License No.: State:						
Name: _									
Name: _ Name: _			License No. : State:						
Name: _ Name: _ Name: _			License No.: State: License No.: State:						
Name: _ Name: _ Name: _ In the pa □ Yes	ast 5 ye	ars,	License No.: State: License No.: State: License No.: State: License No.: State: Has any applicant: State: Had his or her driver's license suspended or revoked?						
Name: _ Name: _ Name: _ In the pa □ Yes □ Yes	ast 5 ye	ars, a. b. c.	License No.:State:State:						
Name: _ Name: _ Name: _ In the pa □ Yes □ Yes □ Yes	ast 5 ye □ No □ No □ No	ars, a. b. c.	License No.:State:						
Name: _ Name: _ Name: _ In the pa _ Yes _ Yes _ Yes _ Yes Name: _	ast 5 ye No No No	ars, a. b.	License No.:State:						
Name: _ Name: _ Name: _ In the pa _ Yes _ Yes _ Yes _ Yes Name: _	ast 5 ye No No No	ars, a. b.	License No.:State:						
Name: _ Name: _ Name: _ In the pa _ Yes _ Yes _ Yes _ Name: _ Name: _	ast 5 ye □ No □ No □ No	ars, a. b.	License No.:State:						
Name: _ Name: _ Name: _ In the pa _ Yes _ Yes _ Yes Name: _ Name: _	ast 5 ye □ No □ No □ No	ars, a. b. c.	License No.:State:						
Name: _ Name: _ Name: _ In the pa _ Yes _ Yes _ Yes Name: _ Name: _ Ta SF _ Yes	ast 5 ye No No No No	ars, a. b. c.	License No.:State:						
Name: _ Name: _ Name: _ In the pa _ Yes _ Yes _ Yes _ Yes _ Yes _ Name: _ Name: _ The Yes _ Yes _ Name: _ Name: _ The Yes _ Yes	ast 5 ye No No No	ars, a. b. c.	License No.:State:						
Name: _ Name: _ Name: _ In the pa _ Yes _ Yes _ Yes _ Yes _ Yes _ Name: _ Name: _ Name: _ Name: _ Name: _	ast 5 ye No No No	ars, a. b. c.	License No.:State:						
Name: _ Name: _ Name: _ In the pa _ Yes _ Yes _ Yes _ Yes Name: _ Name: _ Name: _ Name: _ Name: _ Table Tell	PORTI	ars, a. b. c.	License No.:State:						
Name: _ Name: _ Name: _ In the pa _ Yes _ Yes _ Yes _ Yes _ Yes _ Yes _ Name: _	PORTION No	ars, a. b. c.	License No.:						
Name: _ Name: _ Name: _ In the pa _ Yes _ Yes _ Yes _ Yes _ Yes _ Yes _ Name: _	PORTION NO	ars, a. b. c. Do par ha:	License No.:						

4E TYPE OF COVERAGE									
15 TYPE OF COVERAGE ☐ Individual ☐ Individual and Spouse ☐ Individual	dual and Child(ren)								
Yes No If you are applying for coverage other than "Individual," are you interested in coverage if one or more applicants is declined or ineligible?									
16 BENEFITS SELECTION									
MUST CHOOSE	ONE BOX ONLY								
Comprehensive Blue PPO III	HSA Blue PPO II								
 □ \$ 1,000 deductible □ \$ 1,500 deductible □ \$ 2,500 deductible 	\$ 1,500 individual/ \$ 3,000 family deductible								
 □ \$ 5,000 deductible □ \$ 7,500 deductible □ \$10,000 deductible 	\$ 2,500 individual/ \$ 5,000 family deductible								
 □ \$15,000 deductible □ \$15,000 deductible □ \$20,000 deductible 	□ \$ 5,000 individual/ \$10,000 family deductible								
□ \$25,000 deductible									
17 OPTIONAL BENEFITS SELECTION									
OPTIONAL MATERNITY BENEFITS									
	overage has been in effect for 12 months. There is no per lable to females age 19 or older. Dependents other than a								

17 OPTIONAL BENEFITS SELECTION (continued) **OPTIONAL TERM LIFE** Underwritten by USAble Life and billed with your health insurance. USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life policy referenced here. Term Life is available only on the proposed insured and spouse. (Proposed insured must be 19 - 64 years of age.) Choose only one of the following: ☐ Proposed Insured ☐ Proposed Insured and Spouse (Spouse must also be applying for health insurance coverage on this application.) Choose one of the following coverage amounts: □ \$10,000 □ \$30,000 □ \$50.000 If both the proposed insured and spouse choose Term Life, the coverage amounts will be the same. • Benefits will be paid to the designated beneficiary(ies) in one lump sum. • Premiums are based on the age of the oldest person applying for coverage and increase when that person's age moves to the next age bracket. Your monthly premiums will be billed with your Arkansas Blue Cross and Blue Shield health insurance coverage. · Your Term Life coverage will become effective at the same time as your Arkansas Blue Cross and Blue Shield health insurance coverage. **Beneficiary Designation for Optional Term Life Insurance Benefits** I hereby designate the following beneficiary(ies) for the USAble Life Term Life insurance and revoke the appointment of any existing beneficiary, if making a change in beneficiary(ies). If I designate more than one beneficiary, those who survive will share equally unless specified otherwise. The beneficiary for the Term Life insurance on a covered spouse will be the proposed insured. **PRIMARY BENEFICIARY(IES)** (Will receive proceeds if living at death of proposed insured.) Percentage Date Address Relationship Name (First, MI, Last) Social Security No. of Birth Distribution Total must equal 100% = CONTINGENT BENEFICIARY(IES) (Will receive proceeds if all primary beneficiary(ies) are not living.) Date Percentage Relationship Name (First, MI, Last) Address Social Security No. Distribution of Birth

Total must equal 100% =

18 EX	(PECTANT/A	DOPTIVE	PARENT INFORMA	TION							
☐ Yes	□ No Is any m	nale applying	for coverage an expectan	t father or a p	otential	adoptiv	ve fath	er?			
☐ Yes	Yes No Is any female applying for coverage pregnant or a potential adoptive mother?										
If "yes,"	f "yes," please provide the following: Name:Expected Delivery/Adoption Date:/										
19 IN	FERTILITY										
Has any	applicant or sp	ouse of a pr	oposed applicant (wheth	er applying	for cov	erage	or not) :			
	☐ Yes ☐ No a. Ever been diagnosed or treated for infertility?										
□ 163	Name: Treatment/Procedure: Date: / /										
	Name:										
20 TC	20 TOBACCO USAGE										
☐ Yes											
	·		Type/Amour	nt:			_ Date	Last Used:	/	/	
	Name:		Type/Amour	nt:			_ Date	Last Used:	/		
	Name:		Type/Amour	nt:			_ Date	Last Used:	/	/	
21 PR	REVIOUS INS	URANCE	EXPERIENCE								
☐ Yes	☐ No Has any or long-	y applicant e term care in	ever been declined, rated, surance? If "yes," please	restricted or provide the	modifie	ed for t g:	he issı	uance of life, ac	cident, h	nealth	
	Name:	· · · · · · · · · · · · · · · · · · ·	Carrier Name:	· · · · · · · · · · · · · · · · · · ·	Yea	ar:	De	tails:			
	Name:		Carrier Name:		Yea	ar:	De	tails:			
22 PF	RESCRIPTIO	N QUEST	IONNAIRE								
If you ar	prescrip nswered "yes," ne same inform	otion medical please proviation required the nation required to the nation required the national require	plicant currently taking a tion in the last 3 years? ride full details below. Us ested here and must be ame that would have be	se separate e signed an	sheet if	neces d . A pr	sary. <i>I</i> int out	Any attachment from the pharm	nt must	not	
Person Treated	Name of Drug	Dosage	Specific Disorder or Illness	Start Date/ Stop Date		of Rec		Complet Address of Pre			
Treateu	Of Drug		Of filliess	Stop Date	None	Partial	Full	Address of Fig	sociulity	Filysiciali	
				mo year							
				mo year							
				mo year							
				mo year							
				mo year							
				mo year							
				mo year							
				mo year							
				mo year							
				mo vear							

23 MEDICAL QUESTIONNAIRE

☐ Any other disorder of stomach, intestines,

■ None of the above apply to any applicant(s)

liver, gallbladder or rectum

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

1.	medical conditions are listed, please circ	cle all conditions that apply.)	st one box	checked. When multiple
A	BRAIN OR NERVOUS SYSTEM DISORDERS Alzheimer's disease or senile dementia Amyotrophic lateral sclerosis (Lou Gehrig's disease) Cerebral palsy Concussion or brain injury Convulsions, epilepsy or seizures Headaches or migraines Meningitis Multiple sclerosis, muscular dystrophy or myasthenia gravis	D. KIDNEY, URINARY, REPRODUCTIVE □ Abnormal pap smear □ Bladder or renal stones □ Cesarean section or miscarriage □ Dialysis □ Nephritis □ Nephrotic syndrome, renal disease or failure □ Sexually transmitted disease □ Sugar, blood or protein in urine □ Any other disorder of the kidneys or urinary tract □ Any other disorder of the male reproductive organs, including prostate □ Any other disorder of the female reproductive organs, including ovaries or breasts □ None of the above apply to any applicant(s)	☐ Fracture Expose ☐ Gout ☐ Lupus, ☐ Tempore or cran ☐ Any oth or joints ☐ None of ☐ Catara ☐ Meniere ☐ Nasal s	ULOSKELETAL (cont.) re(s) or broken bone(s) red bone □ Yes □ No systemic romandibular joint disorder (TMJ/TMD) riomandibular disorder rher disorder of the muscles, bones red to include chiropractic care red the above apply to any applicant(s) VEYES/NOSE/THROAT rects or glaucoma re's disease respetal defect rectis, tonsillitis or otitis media
	Any other disorder of the brain or nervous system	E. RESPIRATORY □ Allergies, asthma or bronchitis	☐ Any otl throat o	her disorder of the eyes, ears, nose, or esophagus of the above apply to any applicant(s)
B	artery disease, stent placement or angioplasty Cerebrovascular accident (stroke), including	 □ Chronic pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV) □ Obstructive or reactive airway disorder □ Sleep apnea, cpap, bipap or vpap □ Any other disorder of the lungs, bronchial tubes or respiratory system □ None of the above apply to any applicant(s) 	ABUSE ☐ Anxiety emotion ☐ Attempt	r, insomnia, sleep disorder, depression, nal problems or nervous disorder ted suicide eling or psychiatric treatment (in-patient
	palpitation of the heart, ablation, rheumatic fever Heart bypass surgery, pacemaker implant Heart or vein/artery surgery High blood pressure Hemophilia Valve repair/replacement Any other disorder of the heart, blood,	F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS □ Anemia □ Cancer, leukemia or malignancy of any kind □ Hodgkin's or Non-Hodgkin's disease □ Melanoma, neoplasm or tumor □ Any other disorder of the lymphatic system □ Any other disorder of the skin	☐ Bipolar or deve ☐ Eating (☐ Any oth or situa ☐ None o	disorder, obsessive compulsive disorder elopmental disorder disorder mental, emotional disorder stion, including ADD/ADHD of the above apply to any applicant(s)
	blood vessels or circulatory system None of the above apply to any applicant(s)	□ None of the above apply to any applicant(s) □ G. GLANDULAR DISORDERS		g Surgery Surgery Date:/_/_
	procedure	□ Adrenal disorders □ Diabetes, abnormal glucose □ Goiter or thyroid disease □ Any disorder of the pancreas □ None of the above apply to any applicant(s)	☐ Salin☐ Any otl internal (i.e.: pir☐ Acquire	implants ne □ Silicone Surgery Date:// her implant(s), prosthetic device(s), I fixation device(s) or retained hardware ns, wires, screws, shunts, stents) ed immune deficiency syndrome
	Hepatitis Hernia, hemorrhoids	H. MUSCULOSKELETAL ☐ Arthritis, osteoarthritis, degenerative joint or disc disease ☐ Back pain and/or neck pain ☐ Chronic fatigue ☐ Connective tissue disorder	deficier ☐ Transpl ☐ Any inju or cond	or AIDS-related complex or immune ncy disorder or HIV lant recipient ury, deformity, incapacitation, disease lition not listed elsewhere of the above apply to any applicant(s)

 \square Disease or disorder of the joints: knee(s),

shoulder(s), elbow(s), wrist(s), other

☐ Fibromyalgia, bursitis or tendonitis

23 MEI	DICAL QU	ESTIC	ONNAIRE (contir	nued)							
2. Has a	ny applicant e	ver:									
☐ Yes			med alcohol to excess	received tre	atment, or io	ined an ord	nanizatio	n for al	coholis	m or dru	g addictions?
	 ☐ Yes ☐ No a. Consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions? ☐ Yes ☐ No b. Used any addictive or non-addictive drug or substance for purposes other than recommended by your physician? 										
	☐ Yes ☐ No c. Been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider, or had any indication(s) of having a drug dependency/habit?										
☐ Yes	ь П Ио д		ed the assistance of ar				of any a	rtivities	of dails	v livina?	If "Ves "
□ 160	з <u>шио</u> а.		explain:	ly other marv	idual for peri	omances	or arry at	Juviucs	or dail	y livilig:	11 100,
☐ Yes	о П No o	•	old that he/she has or	has had haar	ing problem	o oor dioor	dor(a) or	hac no	od of h	ooring d	lovioos duo
□ res	s uno e.		kind of hearing or ear i								
		to arry	Kind of fleating of ear i	піраппіені, с	or does arry a	аррисані на	ave an ex	distilig i	learing	aiu uevi	ce in place?
			ADDITIO	NAL ME	DICAL IN	IFORM.	ATION				
O: fII	data:la ta a	4:							4 -		
			answered affirmative	• '		,				•	
			condition/illness ple						-		•
	•		sts, hospitalization, e			-					
	•		py, physical therapy,	•		•				•	
the treatr	ments that ap	ply. Ple	ease use the name	that would	have been	given at t	the time	of the	phys	ician vi	sit — e.g., a
maiden ı	name.										
Question	Person	Sn	pecific Disorder/Illness	Date of	Date of	Total #	Degree	of Rec	overv	Coi	mplete Name
Number(s)	Treated		nd Type of Treatment	First Visit	Last Visit	of Visits		Partial			dress of Physician
						0	INOTIC	<u>ı artıar</u>	I uii		
				//	/ NOOT						
				mo year	mo year						
				/	/						
				mo year	mo year						
				/	/						
				mo year	mo year						
				/	/						
				mo year	mo year						
				/	mo voor	_					
				mo year	mo year						
24 PH	YSICIAN I	NFOR	RMATION (Please	provide for	or each ap	plicant f	or the	last fi	ve ye	ars)	
	olicant's Name		Complete Nar				Date	of	Reas	son	Treatment/
	oncarit s ivarie		Complete Nai	ne and Addre	33 OFF HYSICI	an	Last Vi	sit*	for Vi	sit**	Results**
*Dlease wei	to NO VICIT in 4	hie hov i	f the applicant has never	seen the physic	cian **II	ea "Common	te" coctic	on Do	10 0 if ~	ore room	is needed for details
LICASE MIII	IC IAO AIOII III [i iio dux li	i ine applicant nas never :	seen we pnysi	uan. US		เอ จะแบบ	I OII Pa(in in a	10011	is needed for detalls

Form No. U-65 List Bill IA (R01/12) Page 7 (Continued on page 8)

PLEASE READ BEFORE SIGNING

By completing this list bill application, which authorizes my employer to remit my premium to Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), I understand and agree: (1) My employer will payroll deduct my premium from my compensation and remit the premium amount to COMPANY. (2) My employer is not acting as an agent of COMPANY but is, instead, at all times acting as my representative. (3) I am responsible for the payment of the premium. Therefore, if my employer fails to submit the required amounts when due, all coverage will terminate as of the due date. (4) If my employer fails to submit the required amounts when due, COMPANY has no obligation to seek payment directly from me. (5) I will not hold COMPANY liable for loss of coverage or benefits due to failure by my employer to remit payment in a timely manner. (6) My coverage is not dependent upon this billing arrangement; therefore, I may change to having COMPANY bill me directly with 15 days advance written notice to my employer and COMPANY. (7) I understand that termination of my employment shall terminate payroll deduction and employer remittance of premium to COMPANY. (8) I understand that my employer or COMPANY may terminate this arrangement by giving me written notice, but this will not terminate my insurance coverage. (9) If this payroll deduction and premium remittance is terminated, in order for me to keep my insurance coverage in force, I must make premium payments directly to COMPANY.

I UNDERSTAND: (1) This application will be medically underwritten in order to assess the potential financial risk of each individual on the application. As the result of the assessment, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, I may have particular conditions or body parts excluded, or I may be declined for coverage. If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/ or offered coverage with non-medical exclusions. (2) If I am age 19 or older, I will not have any benefits provided for 12 months for the treatment of any condition which existed before the effective date of my coverage. (3) The agent or broker involved in this insurance transaction may receive compensation from the COMPANY or one of its affiliates, for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (4) Any coverage which may be issued to me shall be invalid if based on intentional misrepresentation of material fact provided by me on the application. (5) The COMPANY may phone me for additional information that may help with the timely processing of my application. (6) The Health insurance and Term Life insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) understand that the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request.

I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE SECTION (PIE	ase sign appropriate line only)	
Proposed Insured OR		Date Signed
Parent/Legal Guardian's (if policy for a minor)	x	
Spouse		Date Signed
(required if applying)	X	
Dependent age 18 or older (required if applying)	V	Date Signed
Dependent age 18 or older	X	Date Signed
(required if applying)	x	3 3 3
CUSTODIAL PARENT SECT	TION	
If any dependents, under	age 19, named on this application do NOT reside with the proporthe custodial parent's signature is required.	sed insured,
Custodial Parent's Name and Address (please print)	x	Telephone No.
Custodial Parent's		Date Signed
Signature	x	
This section to be complete	-	
	wledge, will the coverage applied for replace or change any existing hospit is coverage is approved by Arkansas Blue Cross and Blue Shield and acco	
Sales Rep License No. (required)	Sales Representative's Name (Please Print) X	Telephone No.
Agency Federal Tax ID No. (if applicable)	Sales Representative's Signature	Date Signed
	X	
Comments:		

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

POLICY EFFECTIVE DATE

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 1st of the **month after next** if the application is approved on the 11th through the end of the **current month**.

Approval Date 1st - 10th 11th - last day of the month 1st of the following month
1st of the month after next

Examples
Approved Jan. 2; effective Feb. 1
Approved Jan. 27; effective Mar. 1



Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 2181, Little Rock, AR 72203-2181 www.ArkansasBlueCross.com



Individual/Family Health Insurance Underwriting Change Form

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS CHANGE FORM. CHANGE FORM MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This form is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This change form must be completed in dark blue or black ink. Forms completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this form.
- Any **attachments** submitted with the change form must be signed and dated.
- Do not send any money with this change form.
- Please ensure all required parties have signed and dated the change form prior to submission.
- We strongly recommend you make a copy of this completed change form for your records.

IMPORTANT INFORMATION REGARDING GRANDFATHERED PLANS

Your Arkansas Blue Cross and Blue Shield coverage **may** be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Arkansas Blue Cross and Blue Shield Customer Service at 1-800-238-8379. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

INSTRUCTION SHEET

Changes to your policy can only be made during the annual open enrollment period, unless the change is a result of a qualifying life event such as birth of a child, adoption, loss of other coverage, marriage, etc.

When you are completing this form, please refer to your Arkansas Blue Cross and Blue Shield identification card for your Member ID and Group #. This information must be entered correctly under Section 1 in order to process your request.

Effective Date: The effective date for any changes requested as a result of a qualifying life event will be the next available effective date following approval. Changes requested during the annual open enrollment period will become effective the following January (the 1st or the 15th of the month, depending on your billing date).

SECTION 5 - U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or green card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- Applicants must reside in the U.S. at least one year prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

SECTION 6 – ADDING SPOUSE OR DEPENDENT(S)

Qualifying life event changes allow you to make changes to your policy outside of the annual open enrollment period. Such events include, but are not limited to:

- Obtaining guardianship, legal custody of a child, or court order requiring coverage for a dependent (requires proof of guardianship, legal custody or court order)
- Death of policyholder or covered member (requires a copy of death certificate)
- Loss of Eligibility (requires a Certificate of Creditable Coverage)
- Marriage (requires a copy of the marriage certificate)

SECTION 8 - BENEFIT CHANGES

- This section reflects all benefit options under your policy.
- Please complete **only** the section for your specific policy.
- If you are unsure of your product name, use the product group numbers listed as a reference. Your product group number can be found on your identification card under **Group #**. It will be the first six numbers before the dash.
- If you still have guestions, call customer service at **1-800-238-8379**.

Detach and keep for you records.

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.



Underwriting Change Form For Current Policy

Return To: Arkansas Blue Cross and Blue Shield, Attn: Individual Underwriting, P.O. Box 2181, Little Rock, AR 72203-2181 or fax to 501-378-3752

1 CURRENT POLICE	CYH	IOLDER INFORMA	TION							
Member ID:		Group N	umber:			Date of	Birth:	/		
First Name:		M.I.: Las	t Name:			Soc	ial Security I	No.: _		
Residential Address:	esidential Address: City: State:								<u>Zip:</u>	
2 CONTACT INFORMATION										
Primary Phone Number ()	AI (to Call M	E-	-mail Addre	ess	com	do you premunicate w E-mail I	
CHANGES TO BE MADE Regardless of the change(s) you are requesting, you must complete sections 9-21.										
POLICY CHANGE ELIGIBILITY										
Check all applicable box		_	change reg	uest.						
□ 1-Annual Open Enrollment Period □ 6-Divorce or Legal Separation □ 9-Involuntary loss of other health coverage □ 2-Birth □ 7-New Guardianship/Legal □ 10-Military Leave □ 3-Adoption □ 4-Death □ 8-Loss of employer-sponsored □ 12-Other (Give specific details) □ 5-Marriage health coverage □ 10-Military Reinstatement □ 12-Other (Give specific details) □ 15-Marriage health coverage □ 10-Military Reinstatement □ 12-Other (Give specific details) □ 15-Marriage health coverage □ 10-Military Reinstatement □ 12-Other (Give specific details) □ 15-Marriage license Form is not received during Open Enrollment Period, you must submit appropriate documentation with Change Form to confirm qualifying life event (i.e. copy of birth or death certificate, copy of marriage license, Certificate of Creditable Coverage from previous insurance company, guardianship/custody documentation, etc.)										
4 POLICY APPEAL	S									
☐ Request for Reinstate	mer	nt:								
. ☐ Remove Tobacco Sur								Quit	i/_	
☐ Remove Other Surcha										
☐ Remove Exclusion:		Name			Ex	cluded Co	ndition			
		Name			Ex	cluded Co	ndition			
5 U.S. CITIZENSHIF	s.	TATUS								
Additional information red □ Yes □ No Are all ap Name: _	•				e(s) of	-	ant(s) who ar	e not	U.S. citizen	S.
6 ADD SPOUSE OF	R D	EPENDENT(S)								
Read instructions for Sec	tion	6 before completing.								
First Name	M.I.	Last Name	Suffix	Relationship	Sex [Date of Birth	Social Security	y No.	Height	Weight
									ftin.	lbs.
									ftin.	lbs.
									ftin.	lbs.
									ftin.	lbs.

7 ADD MATERNITY		
AccessBlue PPO (Not an option) BlueCare PPO BlueCare PPO Plus Blue Choice Blue Select \$2,000 \$3,000 \$5,000 Blue Solution PPO Comprehensive Blue PPO Comprehensive Blue PPO II Comprehensive Blue PPO III	sic Blue PPO (Not an option)	Conversion (Not applicable) HSA Blue PPO HSA Blue PPO Plus HSA Blue PPO II UniqueCare UniqueCare Blue \$2,000 \$3,000 \$5,000 UniqueCare Blue Preferred Farm Bureau FlexPlan Farm Bureau FlexPlan Preferred
8 BENEFIT CHANGES		
AccessBlue PPO Group # 7001 Decrease my calendar-year deductible group # 30010 Decrease my calendar-year deductible group # 30010	to: \$500 01-300104 or 300201-300204 - No	□ \$1,000
Value PPO Group # 710000 Add benefit:	or 720000 - Grandfathered Physician Office Visits Rider	☐ Prescription Drugs Rider
BlueCare PPO Group # 600010-60 BlueCare PPO Plus Group # 600 Decrease my calendar-year deductible to Decrease my calendar-year coinsurance	0030-600036 or 600040-600046 - to: □ \$500	Grandfathered ☐ \$1,000 ☐ \$1,500
Blue Choice Group # 771000-77100 Decrease my calendar-year deductible a		nered
\$500 Deductible Options ☐ \$1,000 OOP* coinsurance maximum ar ☐ \$1,000 OOP* coinsurance maximum ar ☐ \$2,000 OOP* coinsurance maximum ar ☐ \$2,000 OOP* coinsurance maximum ar	nd CC Rx plan nd EC Rx plan nd CC Rx plan	\$5,000 Deductible Options ☐ \$30/\$50 copay and CC Rx plan ☐ \$30/\$50 copay and EC Rx plan ☐ No physician copays** and CC Rx plan ☐ No physician copays** and EC Rx plan
\$1,000 Deductible Options ☐ \$1,000 OOP* coinsurance maximum ar ☐ \$1,000 OOP* coinsurance maximum ar ☐ \$2,000 OOP* coinsurance maximum ar ☐ \$2,000 OOP* coinsurance maximum ar	nd EC Rx plan nd CC Rx plan	\$10,000 Deductible Options ☐ \$30/\$50 copay and CC Rx plan ☐ \$30/\$50 copay and EC Rx plan ☐ No physician copays** and CC Rx plan ☐ No physician copays** and EC Rx plan
\$2,500 Deductible Options ☐ No OOP* coinsurance and CC Rx plan ☐ No OOP* coinsurance and EC Rx plan ☐ \$2,000 OOP* coinsurance maximum ar ☐ \$2,000 OOP* coinsurance maximum ar *Out-of-Pocket	nd CC Rx plan	\$25,000 Deductible Options ☐ \$30/\$50 copay and CC Rx plan ☐ \$30/\$50 copay and EC Rx plan ☐ No physician copays** and CC Rx plan ☐ No physician copays** and EC Rx plan **Physician visits subject to deductible.
Decrease my calendar-year deductible to Decrease my calendar-year coinsurance	to: □ \$500	

8 BENEFIT CHANGES (continued)							
Blue Solution PPO Group # 770000-770003	3 or 780000-780003 - Grandfathered						
Decrease my calendar-year deductible to:	□ \$750 □ \$1,500 □ \$3,000						
▼ Comprehensive Blue PPO Group # 7900	000-790007 or 700000-700007 - Grandfathered						
Comprehensive Blue PPO II Group # 79							
Decrease my calendar-year deductible to:	□ \$500 □ \$1,000 □ \$2,500 □ \$5,000 □ \$10,000						
Y =	000-300007 or 390000-390007 - Non-Grandfathered						
•	91000-398000 or 301000-308000 - Non-Grandfathered						
Decrease my calendar-year deductible to:	□ \$500 □ \$1,000 □ \$2,500 □ \$5,000 □ \$10,000						
▼ Comprehensive Blue PPO III Group # 70	00008-700016 or 790008-790016						
	□ \$1,000 □ \$1,500 □ \$2,500 □ \$5,000						
L	□ \$7,500 □ \$10,000 □ \$15,000 □ \$20,000 □						
Conversion Group # 902100-902140 - Grandfa							
Conversion Group # 302100-302140 - Non-Gra Decrease my calendar-year deductible and benefit							
□ \$ 100 Deductible, 80/20% Coinsurance, \$5,000 C							
☐ \$ 500 Deductible, 80/20% Coinsurance, \$5,000 C							
☐ \$1,000 Deductible, 80/20% Coinsurance, \$5,000 C	Calendar-Year Coinsurance Maximum						
HSA Blue PPO Plus Group # 750000-75002 Decrease my calendar-year deductible and benefit □ \$1,200 Individual/\$2,400 Family Deductible, 80/20% □ \$3,100 Individual/\$6,250 Family Deductible, 80/20%	HSA Blue PPO Group # 730000-730021 or 740000-740021 - Grandfathered HSA Blue PPO Plus Group # 750000-750021 or 760000-760021 - Grandfathered Decrease my calendar-year deductible and benefit to: □ \$1,200 Individual/\$2,400 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Family Coinsurance Maximum □ \$3,100 Individual/\$6,250 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Family Coinsurance Maximum □ \$3,100 Individual/\$6,250 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum						
▼ HSA Blue PPO II Group # 711000-711005 or	722000-722005 - Grandfathered						
Decrease my calendar-year deductible to:	☐ \$1,500 Individual/\$3,000 Family Deductible ☐ \$2,500 Individual/\$5,000 Family Deductible						
▼ HSA Blue PPO II Group # 311000-311005 or							
Decrease my calendar-year deductible to:	□ \$1,500 Individual/\$3,000 Family Deductible						
	□ \$2,500 Individual/\$5,000 Family Deductible						
Uniquecare Group # 610100-611000, 620100-621000 or 650100-651000, 660100-661000 - Grandfathered Uniquecare Blue Group # 600100-600114, 600200-600214 or 600300-600311, 600400-600410 - Grandfathered Uniquecare Blue Preferred Group # 622001-622016, 633001-633016 - Grandfathered Farm Bureau Flexplan Group # 809031-809046 - Grandfathered Farm Bureau Flexplan Preferred Group # 808001-808027 or 808004-808028 - Grandfathered							
Decrease my calendar-year deductible and benefit	it to:						
Deductible: ☐ \$500* *Not available with Plan A (100% Coinsurance)	□ \$1,000* □ \$2,500 □ \$5,000 □ \$10,000						
Choice of Plan: **Coinsurance Maximum amount not applicable	☐ Plan A: 100%** Coinsurance ☐ Plan B: 80/20% Coinsurance						
Calendar-Year Coinsurance Maximum:	□ \$2,500 □ \$10,000						

9 HO	USEH	OL	D INFORMATION
☐ Yes	☐ No	a.	Do all applicants reside in the same household? If "no," please provide:
			Name: Address:
			Reason:
☐ Yes	□ No		Do all applicants reside in Arkansas? If "no," please provide:
			Name: Address:
40			Reason:
			T(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]
			Employer:
			Employer:
11 CI	JRRE	NT	INSURANCE COVERAGE
□ Yes	□ No	a.	Will the coverage applied for replace or change current hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant? i. If "yes," please provide name of carrier: ii. If "yes," does the coverage have a specified termination date? If so, please provide date:/_/
□ Yes	□ No		 iii. If "yes," and the coverage does not have a specified termination date, will the coverage terminate if approved by Arkansas Blue Cross and accepted by the applicant?
□ Yes	□ No	b.	Have you recently lost employer-sponsored health coverage? If "yes," please provide: Name: Carrier Name: Termination Date:/_/
			Name:Carrier Name: Termination Date:/_/
☐ Yes	□ No	C.	Have you recently "involuntarily" lost other health coverage? If "yes," please provide:
			Name:Carrier Name: Termination Date:/_/
□ Voc		٨	Name:Carrier Name: Termination Date:/_/ Will any applicants be continuing any other health insurance? If yes, please provide:
LI IES		u.	Name: Carrier Name: ID#
			Name: Carrier Name: ID#
□ Yes	□ No	e.	Are any applicants covered by Medicaid (other than Women's Health/Family Planning coverage)? If "yes," please provide name(s) below: Name:
			Name:
□ Yes	□ No	f.	Are any applicants covered by Medicare? If "yes," please provide name(s) below: Name:
			Name:
12 DE)I\/ED	, C	LICENSE INFORMATION [applicant(s) age 14 and older]
Name: _			License No. : State:
Name: _			License No.: State:
Name: _			License No.: State:
In the pa	ast 5 ye	ars	, has any applicant:
☐ Yes	□ No	a.	Had his or her driver's license suspended or revoked?
			Had two or more moving traffic violations?
☐ Yes	□ No		Been convicted or charged with driving under the influence of alcohol or a controlled substance?
			If you answered "yes," to any of the above questions, you MUST provide the following information:
			Date:/Violation(s):
Name: _			Date:/Violation(s):
13 SF	PORTI	NG	GOR HOBBY INFORMATION
☐ Yes	□ No	ра	bes any applicant intend to pilot a private aircraft; race a motor vehicle, boat or snowmobile; or rticipate in sky or scuba diving, ballooning, mountain climbing, hang gliding or any other zardous sport, hobby or activity?
Name:			Please explain:
Name:			Please explain:

14 TR	AVEL	OUTSIE	DE THE	USA							
	- 1	lf "yes," pl	ease prov	lanning to travel or work vide the following:		USA	within 1	the nex	kt two years?		
				ated Length of Ctory			loto:		Datum	data	
Reason f				cted Length of Stay:			iale:		Relum	date: _	
	101 1101										
15 EX	PECT	ANT/AD	OPTIVE	PARENT INFORMA	TION						
☐ Yes	□ No	Is any ma	le applying	g for coverage an expectan	t father or a p	otentia	I adoptiv	ve fathe	er?		
☐ Yes	□ No	Is any fem	nale apply	ing for coverage pregnant o	or a potential	adoptiv	e mothe	er?			
If "yes," p	olease pr	rovide the	following:	Name:		Expect	ed Deliv	ery/Ad	loption Date: _		/
16 INI	FERTI	LITY									
Has any	applica	nt or spou	ise of a pi	oposed applicant (whether	er applying	for co	verage	or not) :		
			_	nosed or treated for infertil	,						
☐ Yes			•	rilization? If "yes," please			•		Data:	,	1
				Treatment/f Treatment/f							
47 =0				Treatment	Tocedure				Date		
		O USA									
		provide th	e followin	•						•	
				Type/Amoun							
				Type/Amoun							
	Name:			Type/Amoun	t:			_ Date	Last Used:	/	/
18 PR	EVIOL	JS INSU	RANCE	EXPERIENCE							
☐ Yes				ever been declined, rated, surance? If "yes," please				he issu	ance of life, ac	cident, l	health
				Carrier Name:							
	Name:			Carrier Name:		Ye	ear:	Def	tails:		
19 PR	ESCR	IPTION	QUEST	IONNAIRE							
☐ Yes				plicant currently taking a ation in the last 3 years?	ny prescription	on med	lication,	or has	any applicant	taken	
				e full details below. Use se and must be signed and							le all of the
		-		d have been used at the ti				•	•	•	een used.)
Person	N	ame	_	Specific Disorder	Start Date/	Degre	ee of Red	covery	Comple	ete Name	and
Treated		Drug	Dosage	or Illness	Stop Date		Partial		Address of Pr		
					1						
					mo year						
					mo year						
					mo /year						
					mo year						
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					mo year						
					mo year						
					mo year						
					/						
					mo year						
					mo year						
					mo vear						

20 MEDICAL QUESTIONNAIRE

liver, gallbladder or rectum

■ None of the above apply to any applicant(s)

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

1. Has any applicant **ever** had or been told he/she had: (Each section must have at least one box checked. When multiple medical conditions are listed, please (circle) all conditions that apply.)

	medical conditions are listed, please circ	cle	all conditions that apply.)		
	medical conditions are listed, please cire BRAIN OR NERVOUS SYSTEM DISORDERS Alzheimer's disease or senile dementia Amyotrophic lateral sclerosis (Lou Gehrig's disease) Cerebral palsy Concussion or brain injury Convulsions, epilepsy or seizures Headaches or migraines Meningitis Multiple sclerosis, muscular dystrophy or myasthenia gravis Neuritis Paralysis or palsy Parkinson's disease Polyneuritis Vertigo, fainting or dizziness	$\overline{}$	KIDNEY, URINARY, REPRODUCTIVE Abnormal pap smear Bladder or renal stones Cesarean section or miscarriage Dialysis Nephritis Nephrotic syndrome, renal disease or failure Sexually transmitted disease Sugar, blood or protein in urine Any other disorder of the kidneys or urinary tract Any other disorder of the male reproductive organs, including prostate Any other disorder of the female reproductive organs, including ovaries or breasts None of the above apply to any applicant(s)		MUSCULOSKELETAL (cont.) Fracture(s) or broken bone(s) Exposed bone ☐ Yes ☐ No Gout Lupus, systemic Temporomandibular joint disorder (TMJ/TMD or craniomandibular disorder Any other disorder of the muscles, bones or joints to include chiropractic care None of the above apply to any applicant(s EARS/EYES/NOSE/THROAT Cataracts or glaucoma Meniere's disease Nasal septal defect Sinusitis, tonsillitis or otitis media
	Any other disorder of the brain or nervous system	E.	RESPIRATORY Allergies, asthma or bronchitis Chronic pulmonary disease, emphysema, lung		Any other disorder of the eyes, ears, nose, throat or esophagus None of the above apply to any applicant(s
	Angina, heart attack, myocardial infarction Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty	0 00 0	disease or respiratory syncytial virus (RSV) Obstructive or reactive airway disorder Sleep apnea, cpap, bipap or vpap Any other disorder of the lungs, bronchial tubes or respiratory system None of the above apply to any applicant(s)	J.	MENTAL/EMOTIONAL OR SUBSTANCE ABUSE Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder Attempted suicide Counseling or psychiatric treatment (in-patien or out-patient)
	Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever Heart bypass surgery, pacemaker implant Heart or vein/artery surgery High blood pressure Hemophilia	F	OR SKIN DISORDERS Anemia Cancer, leukemia or malignancy of any kind Hodgkin's or Non-Hodgkin's disease Melanoma, neoplasm or tumor		Bipolar disorder, obsessive compulsive disorde or developmental disorder Eating disorder Any other mental, emotional disorder or situation, including ADD/ADHD None of the above apply to any applicant(s
	Valve repair/replacement Any other disorder of the heart, blood, blood vessels or circulatory system None of the above apply to any applicant(s)		Any other disorder of the lymphatic system Any disorder of the skin None of the above apply to any applicant(s)		OTHER Current patient in a hospital or nursing home Pending Surgery Surgery Date:/_/_
c .	DIGESTIVE Cirrhosis Crohn's disease or ulcerative colitis Gastric bypass surgery or other weight loss procedure		GLANDULAR DISORDERS Adrenal disorders Diabetes, abnormal glucose Goiter or thyroid disease Any disorder of the pancreas None of the above apply to any applicant(s)		Sarcoidosis Breast implants □ Saline □ Silicone Surgery Date:/_/ Any other implant(s), prosthetic device(s) internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents) Acquired immune deficiency syndrome
	Irritable bowel syndrome or gastric esophageal reflux disorder (GERD) Pancreatitis Pyloric stenosis	н. 0 0000	MUSCULOSKELETAL Arthritis, osteoarthritis, degenerative joint or disc disease Back pain and/or neck pain Chronic fatigue Connective tissue disorder Disease or disorder of the joints: knee(s),		(AIDS), or AIDS-related complex or immune deficiency disorder or HIV Transplant recipient Any injury, deformity, incapacitation, disease or condition not listed elsewhere None of the above apply to any applicant(s
	Any other disorder of stomach, intestines,		shoulder(s), elbow(s), wrist(s), other		

☐ Fibromyalgia, bursitis or tendonitis

20 N	MEDI	CAL (QU	ESTI	ONNAIRE (cont	inue	d)								
2. Ha	s any	applica	nt e	ever:											
	Yes				med alcohol to excess				-	-				-	
	Yes				iny addictive or non-a		_								
	Yes	□ No	C.		reated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider, any indication(s) of having a drug dependency/habit?										
	Yes	□ No	d.		ed the assistance of	_	_			-	nces of	anv ac	ctivities	of dail	v living? If "Yes
				please	explain:										
П	☐ Yes ☐ No e. Been told that he/she has or has had hearing problems, ear disorder(s) or has need of hearing devices due to any kind of hearing or ear impairment, or does any applicant have an existing hearing aid device in place?														
ADDITIONAL MEDICAL INFORMATION															
Give full details to questions answered affirmatively (checked or answered "Yes") to explain answers to questions in SECTION 20. In addition to condition/illness please provide the type of treatment provided or planned – for example, surgery, X-rays, EKG, lab tests, hospitalization, emergency room visit, nursing home confinement, doctor visits, rehabilitation															
_	-	-			by, physical therapy,	_	-			•					
					ease use the name									-	
maide	en nan	ne.	·												
Questic	I	Perso			ecific Disorder/Illness		ite of	Date		Total #	Degree	e of Rec	overy		mplete Name
Number	r(s)	Treate	ed	ar	nd Type of Treatment	Firs	t Visit	Last	Visit	of Visits	None	Partial	Full	and Add	dress of Physiciar
							/		/						
						mo	year	mo	year	1					
							/		/						
						IIIO	year	mo	year						
							1		/						
						mo	year	mo	year	-					
						mo	/ year	mo	/ year	-					
						1	,		,						
							/		/						
						mo	year	mo	year						
21 I	PHYS	SICIA	N I	NFOF	RMATION (Pleas	e pro	vide f	or ea	ich a	pplicant t					
1	Applica	ant's Na	me		Complete Na	me an	d Addre	ess of l	Physic	ian	Date Last Vi		Reas for Vi		Treatment/ Results**
														<u> </u>	. 10000

*Please write NO VISIT in this box if the applicant has never seen the physician. **Use "Comments" section on Page 8 if more room is needed for details.

PLEASE READ BEFORE SIGNING I UNDERSTAND: (1) This application may be rejected if the applicant is age 19 or older. (2) If accepted, the insurance applied for shall not become effective until the date shown on my schedule of benefits and the adjusted premium, if applicable, is paid in full. (3) If my application is accepted relying on my representations in this document, any coverage which may be issued to me shall be invalid if based on intentional misrepresentations of material fact or fraud. (4) Any members added to my policy will be subject to a 12-month pre-existing waiting period. This means conditions existing prior to the member's effective date of this policy will not be covered until his/her coverage has been in effect for 12 months. (5) My signature authorizes Arkansas Blue Cross and Blue Shield to coordinate benefits under this policy with other insurance I have which is subject to coordination. (6) Arkansas Blue Cross and Blue Shield may phone me for additional information that may help with the timely processing of my application. In signing below. It represent that the statements and answers given in this application and any signed and dated addendum to this application are true, complete and correctly recorded. I certify that I signed this change form in the state of Arkansas. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. SIGNATURE SECTION (Please sign appropriate line only) (Please Print) **Date Signed** Current Policyholder (required if policyholder is X age 19 or older) OR (Please Sign) Parent/Guardian's (if policy for a minor) X Spouse Date Signed (required if applying) X Dependent age 18 or older Date Signed (required if applying) X **CUSTODIAL PARENT SECTION** If any applicant under age 19 (primary applicant or dependent), named on this application, does NOT reside with the proposed insured or the parent/guardian indicated in Section 2, the custodial parent's signature is also required. Telephone No. Custodial Parent's Name and Address (please print) X Custodial Parent's Date Signed Signature X This section to be completed by sales representative To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant? \Box Yes \Box No Sales Rep License No. Sales Representative's Name (Please Print) Telephone No. (required) X Agency Federal Tax ID No. Sales Representative's Signature Date Signed (If applicable) X COMMENTS



IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

	This authorization must be signed by each applic	ant age 18 or older.	
18	Print Name(s)	Signature	Date
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			/
			/
	List applicants under age 18 (Print Name).		
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Applicants age 18		-	
Apı			
		Parent/Legal Guardian's Signature (if policy for a minor)	Date



An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 2181, Little Rock, AR 72203-2181

SERFF Tracking Number: ARBB-127863893 State: Arkansas
Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 50409

Company Tracking Number: NWAD1_CHGFORM (R01/12)

TOI: H161 Individual Health - Major Medical Sub-TOI: H161.005A Individual - Preferred Provider

(PPO)

Product Name: Applications

Project Name/Number: Revised Applications/NwAd_1ChgForm R01/12

Supporting Document Schedules

Item Status: Status

Date:

Bypassed - Item: Flesch Certification Approved-Closed 12/07/2011

Bypass Reason: Not required.

Comments:

Item Status: Status

Date:

Bypassed - Item: Application Approved-Closed 12/07/2011

Bypass Reason: Attached.

Comments:

Item Status: Status

Date:

Bypassed - Item: Health - Actuarial Justification Approved-Closed 12/07/2011

Bypass Reason: Not Rrequired.

Comments:

Item Status: Status

Date:

Bypassed - Item: Outline of Coverage Approved-Closed 12/07/2011

Bypass Reason: Not required.

Comments:

Item Status: Status

Date:

Bypassed - Item: PPACA Uniform Compliance Approved-Closed 12/07/2011

Summary

Bypass Reason: Not PPACA related.

Comments: